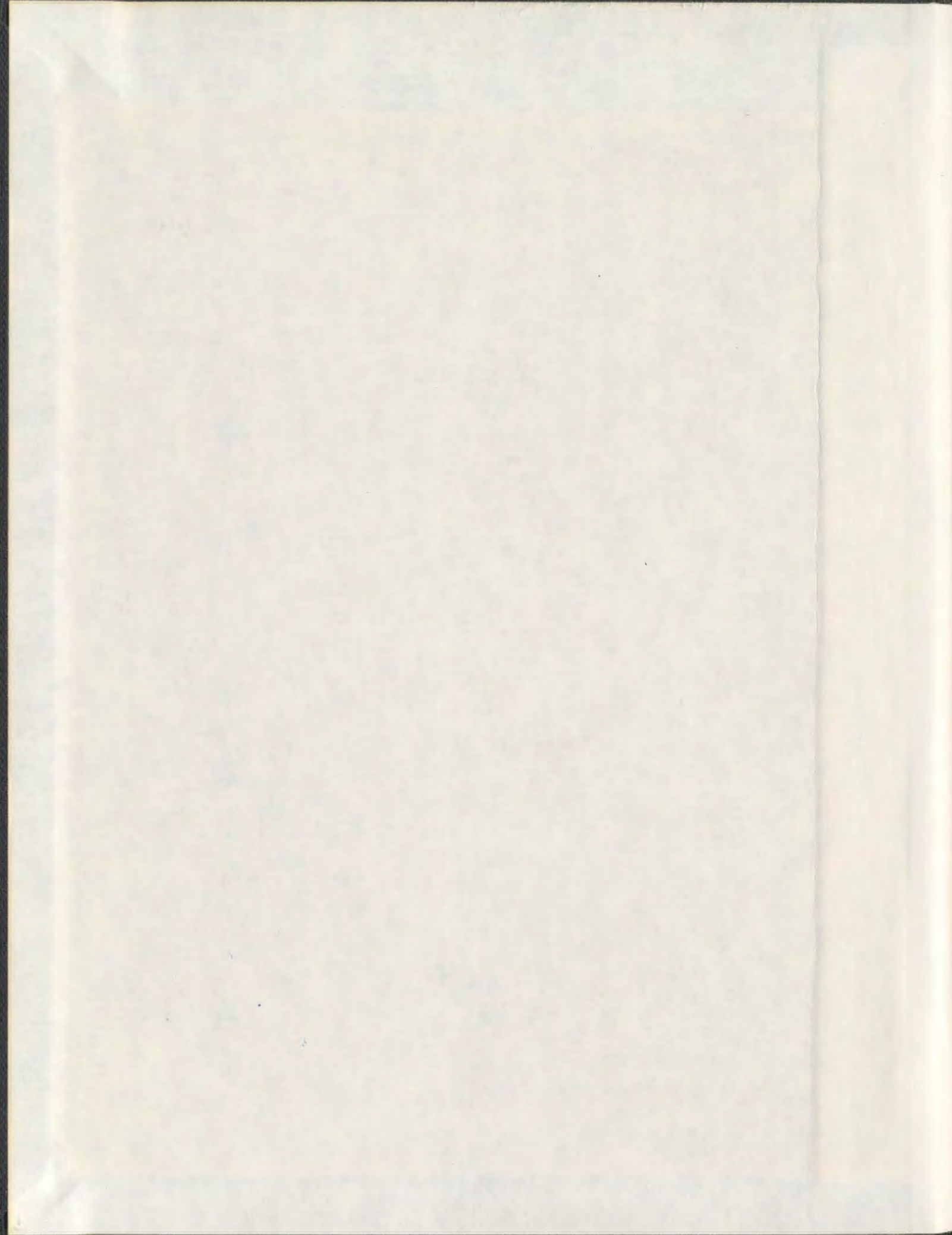


EMOTION MANAGEMENT IN HOSPITAL CHAPLAINCY

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Abstract

This is a qualitative study based on in-depth interviews with professional chaplains working in Toronto hospitals. In order to explore emotional experiences that chaplains undergo as a result of working in hospital and dealing with people who are emotionally overwhelmed, I utilized insights from interactional and symbolic interactionist, phenomenological, ethnomethodological and dramaturgical approaches within the sociology of emotions and spoke with 21 chaplains from five faith traditions (Christianity, Islam, Judaism, Buddhism and modern paganism). The aim was to understand how chaplains manage their work-related emotions in order to protect their mental health, whilst also providing spiritual care. Modern chaplaincy is not about performing religious ritual as much as it is about providing emotional support. As a result, chaplains must be prepared to become deeply involved with emotions. Like a sponge, they should soak up patients' emotions.

Based on actual accounts of work-related emotional experiences, I draw an emotional map for hospital chaplaincy in which typical situations likely to challenge chaplains are pinpointed as emotional hotspots. Emotional challenges are further discussed in terms of spiritual approach vs. medical approach, emotional identification with situation, dealing with baby death, inability to create effective communication, and emotional dissonance. Physical contact and crying, two major outlets of emotional expression, are analyzed in terms of emotion management. I also discuss different techniques, strategies and resources that chaplains rely on to perform their job. The result of the study shows that if chaplains fail to maintain a proper work-life balance, job pressure can be harmful. As a strategy, many chaplains work part-time. As a supportive means, an overwhelming number of chaplains regularly benefit from psychotherapy and/or spiritual guidance.

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Chapter One

Introduction

This dissertation is a qualitative study about emotion management among a category of healthcare providers – hospital chaplains – who have hardly been the subject of sociological research about emotions in previous research. Sociologists of emotion (see, e.g., Turner, 2005) seek to understand how emotions can be socially influenced in terms of both experience and expression. They believe emotions can be influenced by such institutions as culture and religion. As a result, societies and subcultures have different patterns of expressing emotions according to their own norms and characteristics. Based on Arlie Hochschild's (1983) study of flight attendants, an interactional approach emerged in the sociology of emotions, in which emotions are viewed not only as socially constructed phenomena – influenced by occupational feeling rules that dictate how people experience and express their emotions in different situations – but also as phenomena that are actively controlled by employees as part of their paid employment. I used insights from this approach and supplemented them with phenomenological and ethnomethodological understandings of emotion to provide a theoretical framework for studying the emotional experiences of hospital chaplains in Toronto.

The Sociology of Emotions

Human emotions have generally been seen as mysterious phenomena. We sometimes experience strange emotions without realizing what is going on inside us. Our daily lives are full of pleasant and unpleasant, intense or mild, states of mind without

which our definition of self and of identity would be incomplete. We do not intentionally produce these states of mind but are subject to experiencing them. At other times, however, we actively express what we think is “appropriate” to feel. As a result, a number of scholars have been trying to understand human emotion. Sociologists expressed their interest in this topic relatively late. Nevertheless, since the mid 1970s, increasing attention has been paid to studying emotions as sociological phenomena. The sociology of emotions, as a theoretically and empirically promising sub-field of study, was developed by American sociologists in the last quarter of the twentieth century.

In this chapter, I will provide a brief explanation of the two main theoretical approaches that initially developed in the sociology of emotions, and then summarize my theoretical model, research questions, methodology, and present an overview of the thesis. A detailed explanation of different theoretical approaches within the sub-field of the sociology of emotions is presented in chapter two, where I review the literature of this sub-field.

Two Main Theoretical Approaches to Emotions

Before describing the two main theoretical approaches to the study of emotions, it is beneficial to define the term *emotion* itself, a term which has been notoriously controversial in terms of definition. As Thoits (1989:318) argues: “there are almost as many definitions of emotion as there are authors.” A classic definition by two social psychologists (Schachter and Singer, 1962; in Kemper, 1978) says emotions are “relatively short-lived positive or negative evaluative states that have neurological and cognitive elements.” According to Lawler and Thye (1999:218), emotions are “internal

states that are not under the complete control of actors.” Speaking from a socio-physiological perspective, Kemper (1987: 263) defines emotions as “ideal-typically, autonomic-motoric-cognitive states.” For another sociologist, Denzin (1984: 51), emotions are “feelings of self including bodily sensations, sensible feelings, intentional value feeling states and feelings of self as a moral, sacred, or profane object.” Arlie Hochschild (1979: 551) defines emotion as “bodily cooperation with an image, a thought, or a memory of which the individual is aware.” Hochschild uses the terms “emotion” and “feeling” interchangeably, although the term “emotion” for her denotes a state of being overcome that “feeling” does not. In her later work, Hochschild (1983) elaborated on her conception of emotion, defining it as awareness of four elements that we usually experience at the same time: (1) appraisals of a situation; (2) changes in bodily sensations; (3) the free or inhibited display of expressive gestures; and (4) a cultural label applied to specific constellations of the first three elements. We learn how to appraise, display, and label emotion, as we learn how to link the results of each to that of the other. Emotions, Hochschild (1983: 18) believes, communicate information and have a *signal function*: it is through emotions that we discover our own viewpoint on the world.

Clearly, there is no general consensus among scholars on exactly what emotions are. Various definitions emphasize one aspect of emotional experience, and pay scant attention to others. Based on their theoretical inclination, different scholars tend to highlight certain characteristics and ignore others. For example, symbolic interactionists (Shott, 1979) emphasize the importance of interpersonal relations, self, identity and definition of situation, while for supporters of conflict theory (Collins, 1981), it is the conflict between individuals competing for scarce resources that produces emotions. In a

general classification, the sociology of emotions was initially divided into two major camps: *social constructionists*, and *positivists*. The general characteristics of each approach can be described as follows:

The notion that people are spontaneously moved by and subject to emotions is central to the position that emotions are universal, objectively ascertainable, and biologically rooted (Barbalet, 2001). This is essentially a positivist point of view, elaborated on by the works of sociologists such as Kemper (1978, 1981, 1987), and Collins (1981). On the other hand, the idea that people may control or manage their emotions is essential to the view that emotions are cultural artifacts, differing in various societies, significantly subjective, and phenomenologically grounded. This is the social constructionist perspective, which was mostly shaped by the work of Arlie Hochschild (1979, 1983).

Positivists are basically concerned with the biological underpinnings of emotion. In other words, they maintain a critical relationship exists between biological and physiological factors and emotions, and pay insufficient attention to cultural norms and rules that influence emotions. In a positivist approach, one can speak of certain *primary* emotions that are universal in all human societies and form the foundation for the creation of an innumerable number of emotions that are referred to as *secondary* emotions.

Radical proponents of social constructionism, on the other hand, reject the existence of primary emotions altogether, arguing that there is no universal link between psycho/physiological components of emotion and its expressive/situational components. Instead, all emotions are seen as cultural products of society, influenced by and expressed

through feeling rules and cultural norms. For example, Jaggar (1989) talks about the cultural and historical construction of emotions by referring to the existence of emotions in other cultures that are “non-felt” in the West, and the education of children in culturally “appropriate” emotional responses (e.g. to fear strangers). She argues that many emotions make no “sense” without a cultural context: for instance, the feeling of betrayal when there are no social norms of fidelity (Jaggar, 1989: 150).

More moderate supporters of social constructionism, however, accept the existence of primary emotions, but at the same time try to deemphasize their causal influence on producing emotions (Thoits, 1990). Hochschild’s (1979, 1983) work can be placed here, as she attempts to demonstrate the impact that culture has on emotions. For Hochschild (1997: 7), culture is an active, constituent part of emotion, not a passive medium within which biologically pre-formulated, natural emotions emerge. She speaks of an *emotional dictionary* within any culture that determines which feelings are “feelable” and which feelings are not. People live in a *culture of emotion* which tells them how to feel. In America, for example, Hochschild argues that the wedding day is supposed to be the happiest day of one’s life. Those who share this feeling rule are indeed living in the same culture of emotion and have internalized a set of similar feeling rules. Each culture, therefore, has its unique emotional dictionary and its unique *emotional bible*, which defines what should and should not be felt in a given context. A culture’s emotional dictionary and emotional bible, according to Hochschild, determine the way in which people approach an emotional experience.

Although from its early days the sub-field grounded itself in a fundamental division between these two basically different approaches, new approaches eventually

emerged (e.g. Turner, 1999), trying to combine different elements from different theoretical traditions and provide a more comprehensive understanding of emotions. Therefore, a *theoretical continuum* can be defined for different sociological approaches to emotions. Strong versions of social constructionism and positivism constitute the two extremes poles and several different approaches appear in between. Those approaches that emphasize the social construction and subjective nature of emotions (e.g. symbolic interactionism, ethnomethodology, phenomenology, dramaturgical approach, etc.) are close to the social constructionism side of the continuum and those approaches that emphasize the biological, universal and objective nature of emotions (structural/relational approach, conflict approach, etc.) are close to the positivism side. The three approaches that I utilized in my study belong to the first group, where the emphasis is on: (1) feeling rules and cultural norms for managing emotions (interactional), (2) lived experience; bodily ways of experiencing emotions, and the subjective nature of emotions (phenomenology); and (3) indexical, reflexive and contextual emergence of interaction (ethnomethodology). I describe my theoretical framework after explaining why I chose hospital chaplains for a sociological study on emotion management.

Why Study Hospital Chaplains?

I became interested in the work of hospital chaplains as a group of medical personnel whose work often requires emotion management (Cadge, 2009). I wanted to understand how they manage their emotions in order not only to protect their own mental health, but also to provide a service that patients need. I believe the actual costs of emotion management can be serious, multiple and harmful, affecting both the personal

and professional lives of individuals. Potentially, it can also cause serious problems for society at large. Healthcare and medical provision together constitute one of the most important foundations of any society. In order to provide a strong medical service for a healthy society, we should first pay adequate attention to the health and well-being of those who are in charge of providing this service. After reviewing the literature on the relationship between emotion and health, I realized that previous studies have failed to pay adequate attention to the impact of emotional labour on mental health among all categories of healthcare providers. Moreover, I was able to uncover a gap in the literature on the sociology of emotions in healthcare between emotion management and the mental health of caregivers: so far the research emphasis has been more on the organization and less on the individual. And yet, when issues of workers' health are involved, it is nurses and physicians who have predominantly been subjects of research. This gap in the literature can be addressed if one examines those vulnerable personnel who have been ignored in previous research relating to emotion management.

There are several studies (see, for a review, Francis, 2006) on the emotion management of different healthcare professionals, including nurses, doctors, psychologists, etc. However, hospital chaplaincy is a rather recently professionalized occupation which has been little studied. The stereotypical image of a chaplain is that of a Christian clergy in a congregation who, as part of his/her job, sometimes visits parishioners in hospital. For many people, chaplains are committed members of an organized religion, mainly Christianity, whose main job is to perform religious rituals for strongly religious patients. Such a view, as I try to explain in this study, is no longer true. In fact, professional hospital chaplains are specifically trained to be a member of the

medical team. They may not be professionally involved in any organized religion outside of the hospital. As employed and paid members of the hospital in which they work, the chaplains' role is organizationally established like other members of the healthcare system (e.g. physicians, nurses, etc.). Therefore, they may well be subject to specific feeling rules and expectations with regard to the management and expression of emotions. There seems to be little previous sociological study on the emotion management of hospital chaplains, perhaps because their emotional labour is not taken seriously compared to, for example, nurses, or because the number of professional hospital chaplains is not as large as other healthcare professionals, sufficient to constitute an independent group for large-scale survey.

From a sociological point of view, it is important to study hospital chaplains to understand how they bring religion and spirituality into modern, increasingly secular, hospitals and how they establish their role as another group of healthcare professionals whose job is not clinical, like those of physicians and nurses.

Finally, and on a personal level, a topic that stands at the intersection of the sociology of emotions and the sociology of religion is attractive to me because religion and emotions are indeed closely interconnected in my personal life. Being born and raised in a religious family after the Iranian Islamic Revolution, my life has been deeply embedded in a religious context that shapes my perspective toward the universe, gives meaning and purpose to life, constitutes most personal values, determines life-long goals, and more importantly, causes deep moments of emotional experience.

I was not fully aware of this fact until I left Iran for Canada in 2007 and realized that here not only is religion almost invisible (if not completely, at least in the social and

political domains), but it is also carefully separated from public spheres. The omnipresence of religion in Iran and its remarkable silence in Canada is something that I contemplate every day. As a result, I have been interested in studying the influence of religion on human emotions, not in a Durkheimian sense, but in a much wider context, in order to consider the emotional connection of the human individual with the universe. This is the personal reason behind my interest in studying emotion management among hospital chaplains who, before being healthcare professionals, are in most cases believers of a particular religion.

To understand the emotion management of hospital chaplains, I used Hochschild's concepts of emotion management and emotional labour, added to them insights from phenomenology, ethnomethodology, and the dramaturgical approach, and studied the emotional experiences that chaplains go through as a result of working in a hospital. The following section explains how I designed a theoretical framework.

Theoretical Framework of This Study

Among different sociological approaches to emotions, I found Hochschild's symbolic interactionist approach particularly useful because in articulating her theory Hochschild pays specific attention to *emotion management* and *emotional labour* as two central concepts around which the emotional experiences of service providers in an organization can be analyzed. Hochschild elaborated these concepts in such a significant way that in the last twenty years little research has been done on the issue of emotion in organizations that has not referred to them (Bolton and Boyd, 2003: 219). Hochschild's theory provides a powerful framework with which to investigate the strategies that

service providers employ in order to manage their emotions according to the feeling rules of the organization in which they work.

Because hospital chaplains are organizational workers, Hochschild's approach can help us understand how their emotional experiences are influenced by medical standards of care giving. Hochschild is also concerned with individual workers who repeatedly perform emotion mismanagement.¹ She discusses the personal costs and consequences of emotion management, and the impact it has on mental health and emotional well-being. Sociological research on emotion management still continues to reflect many of the broad themes that Hochschild examined more than three decades ago. Wharton (2009) divides these studies into two groups: those that use emotion management as a vehicle to understand the organization, structure, and social relations of particular kinds of service jobs, and those focused more directly on emotions and their management at work. The first line of research proceeds from the vantage point of the occupation, and treats emotional labour as a feature of jobs involving interactive work. These studies tend to be primarily qualitative and ethnographic. The second line of research focuses less on specific occupations than on emotions themselves and workers' attempts to manage them. In other words, personal aspects of emotion management are being examined here. This line of research is predominantly quantitative. Studies of this type are overwhelmingly concentrated around different variants of the concept of *occupational burnout*, which are comprised of three elements: emotional exhaustion,

¹ As a sociologist influenced by Marxism, Hochschild is concerned with members of the working class and middle class strata, with how they are being exploited in business corporations. As a sociologist influenced by Feminism, she is concerned with female members of these classes. Therefore, in her subsequent work (2003) she studied emotional labour in the family and among mothers, who may have to do emotion management both at home and at work.

depersonalization, and a reduced sense of personal accomplishment (Wharton, 2009: 159).

My study can be placed in Wharton's second category, as I am more concerned with personal consequences than with the organizational requirements of emotion management. To understand the emotional experiences of hospital chaplains, we need to move beyond Hochschild's initial theory. Although she explicitly deals with the personal consequences of emotional labour at the individual level, her structuralist influences, such as Marxism and Feminism, potentially restrict analysts from being able to sufficiently explain different forms of emotion management that take place in our contemporary, increasingly complex occupational organizations. In fact, Hochschild's approach has been criticised as too "absolutist" (Bolton and Boyd, 2003: 290), "one-sided," or "moralistic" (Wouters, 1989: 99) to be able to capture the flexible and multi-dimensional nature of emotion management.

In order to better understand emotion management as it is lived by hospital chaplains I draw on a phenomenological approach, presented best in the ideas of Norman Denzin (1984, 1985) who defines emotion as lived experience. Denzin makes it clear from the beginning that self-feeling is at the core of his attention. Self-feeling is described by linking the experience of emotion to the lived body. Denzin sees emotion as a lived experience from a historical, comparative point of view, and conceptualizes emotionality as a relational and historical phenomenon that is uniquely experienced within each historical period. He criticizes those who study emotions as episodic, accidental, or incidental to social experience, arguing that emotions are processes experienced by the self: "what is felt in an emotion is a feeling of self including bodily

sensations, sensible feelings, intentional value feeling states, and feelings of self as a moral, sacred, or profane object” (Denzin, 1984: 51). For Denzin, emotion must be understood from within, as a process that has its own trajectory, or stream of experience. As a phenomenon, it lives within its own dwelling; Phenomenological interpretation of emotion proceeds neither from strict induction nor from deduction, but moves forward through rigorous intuition and understanding.

I found Denzin’s approach useful because it emphasizes the body and different ways through which emotions are lived and experienced in the body. As Francis (2006) argues in her review of the literature on the sociology of emotions in healthcare, most sociological studies on emotion management tend to ignore the existence of the body as a part of emotion. She identifies this problem as a “common deficiency” among studies related to emotion management in healthcare, arguing that studies of nurses’ emotion management underestimate negative impacts of emotion work on human physiology: “emotion in this body of work is virtually entirely social or psychological, with little reference to how they might affect the health or well-being of the people involved” (2006: 599). Francis further argues that the suppression of negative emotions and failure to express naturally felt emotions directly impact mental health.

My third theoretical indebtedness is to ethnomethodology as defined by Garfinkel (1976) and elaborated by micro sociologists such as Cicourel (1973), who studied language and meaning in social interaction. Chaplains perform their job by creating effective communication and providing emotional support through conversation. It is thus important to examine how chaplains actually communicate and initiate interaction with their clients, what emotional dynamics are involved, and what emotional consequences

may result. In interaction with clients, chaplains look for opportunities to address and explore inner sources of strength. Conversations should thus be directed at significant issues by which clients feel emotionally empowered. As we will see, establishing a spiritual connection is not possible unless chaplains create effective communication. An analysis of social interaction based on an ethnomethodological approach, using concepts developed by ethnomethodologists, can actually help us understand this process, namely, how chaplains perform their job as spiritual care providers.

The above theoretical approaches constitute three main components of my theoretical framework to study emotion management in hospital chaplaincy. To a lesser degree, I will also draw on Goffman's dramaturgical theory to describe certain aspects of chaplaincy work.

Summary of the Dissertation

This study is a qualitative study based on in-depth interviewing. I used semi-structured interviewing with hospital chaplains working in different hospitals in the Toronto area. Toronto has a large number of hospitals and medical/healthcare institutions, most of which have a spiritual care department in which a number of full-time and part-time chaplains work to provide pastoral care and spiritual support for patients, their relatives, and other medical personnel. There is a wide range of religious affiliations (Christian, Muslim, Jewish, Buddhist, Hindu, and paganism) among hospital chaplains in Toronto. Approximately 50 chaplains work in different Toronto hospitals.

My sampling method was *purposeful sampling*: a non-random method of sampling in which the researcher selects "information-rich" cases for in-depth interview

(Patton, 2001). On a few occasions, I also relied on another version of purposeful sampling recognized as *snowball* or *chain-referral*: a method of identifying information-rich cases through referrals made by people who possess the characteristics, or know others who possess the characteristics, that are of research interest (Lofland and Lofland, 1995: 38).

My main research questions revolve around the work-related emotional experiences chaplains go through in their daily job while interacting with patients, family members, colleagues, and other medical personnel. For example, how often do they get overwhelmed by emotionally charged situations? What is the most emotionally challenging task in their job? What are the resources or strategies on which they rely in order to protect their emotional well-being and mental health? In order to analyze the data, I used what Sandelowski (2000) calls *qualitative description* with a phenomenological inclination, emphasizing emotional experiences as they are lived by chaplains.

Overall, I visited 19 hospitals to recruit chaplains for my interviews. I spoke with 21 chaplains from 11 hospitals and a diverse range of faith traditions, including Christianity, Islam, Judaism, Buddhism and the modern paganism movement.

The dissertation is comprised of seven chapters. The first chapter introduces the topic, provides a general description of two main approaches within the sub-field of the sociology of emotions, and offers the rationale behind the theoretical framework used to study hospital chaplains. This chapter ends with a brief summary of the dissertation and different aspects of the research. Chapter two is a literature review in which I discuss Hochschild's theory, its shortcomings, and other research it has influenced. Hochschild's

concept of emotion management has been influential in the field of the sociology of emotions; its range of application has gone beyond Hochschild's initial model. I provide a review of emotion management in approaches such as phenomenology, ethnomethodology and dramaturgical theory, explaining how each one of these perspectives can enrich our understanding of emotion management among organizational or service workers. An important goal of this chapter is to locate emotion management in a medical context, emphasizing its complexity and the potential problems that healthcare professionals may face as a result of dealing with emotions. Hospital chaplaincy, as a type of medical profession that requires emotion management perhaps more than other medical professionals, is discussed in the final section of this chapter. The two key concepts of this research, emotion management and hospital chaplaincy, are conceptually discussed.

Chapter three is dedicated to research methods and the methodological problems I encountered during data collection. As I will explain in detail, dealing with the Research Ethics Committees to obtain permission for research was difficult.

Chapter four discusses research findings by explaining what it means to do chaplaincy work from an emotional perspective. Based on chaplains' descriptions of their jobs, this chapter describes typical situations in which professional chaplains interact with patients and family members in order to provide pastoral care and spiritual support.

In chapter five, I outline different challenges and consequences that hospital chaplains may face as a result of working with emotionally overwhelmed clients while trying to perform their job. These challenges are discussed in terms of a spiritual approach vs. a medical approach, emotional identification with the situation, dealing with

baby deaths, inability to create effective communication, and emotional dissonance.

Together with the previous chapter, this chapter provide an *emotional map* for hospital chaplaincy in which *emotional hotspots* are stressed.

Chapter six talks about strategies and techniques of emotion management that chaplains rely on in order to perform their jobs. This chapter is a detailed description of recourses, strategies, rituals, and otherwise necessary means of emotion management that are available to chaplains.

The seventh and last chapter is the concluding chapter. I provide a summary of research findings, as well as a brief discussion on validity, contributions to the literature on the sociology of emotions, the limitations and implications of this research and suggestions for future studies.

Chapter Two

Literature Review

Emotions can be studied from different perspectives. Each perspective has its own areas of emphasis. In this chapter, I start by providing a brief overview of several theoretical approaches in the sociology of emotions, but move on to consider, in detail, those approaches that constitute elements of my theoretical framework, namely, symbolic interactionism, phenomenology, ethnomethodology and dramaturgical approaches. I discuss Hochschild's conceptualization of emotion management in some detail as it is an important part of the theoretical framework used to study chaplains in this research. Although the influence of Hochschild on the work of other scholars is undeniable, it is necessary to move beyond her work in order to consider the idea of emotion management from different points of view. Before elaborating on the concept of hospital chaplaincy, I discuss the importance of emotion management in a medical context as a field in which my own study is situated. As I explain, emotion management among healthcare workers is complicated by multiple factors. I emphasize three major health-related problems (stress, burnout and compassion fatigue) that have been previously recognized as occupational hazards threatening the emotional well-being and mental health of those healthcare professionals who regularly perform emotion management. This chapter ends with a discussion on hospital chaplaincy and its relevance to emotion management.

Sociological Approaches to Emotions

Conflict Approach

In the conflict approach, emotions are products of conflict either at the macro level (e.g. social classes) or micro level (e.g. individuals). This approach is presented best in the work of Randal Collins (1975, 1981, 2004), who asserts that the crucial determinant of emotion is membership in competing groups. Collins is a conflict theorist with a fundamental difference, in that unlike most of conflict theorists, who emphasize macro scale concepts (e.g. Coser, 1966), he puts his emphasis on the micro scale and speaks of actors who are motivated according to the emotional energies they receive from interaction with others. He supports a version of radical microsociology, which is influenced, among others, by the works of Durkheim, Goffman and ethnomethodologists. It is an “empirically detailed” and “phenomenologically sophisticated” sociology aimed at ultra-detailed empirical research.

What Collins suggests is that in order to sample the important microcomponents of macrophenomena and examine them empirically we need a micro mechanism that can explain the repetitive actions that make up social structure such that interactions and their accompanying cognitions rest upon noncognitive bases (1981: 985). This mechanism in Collins’s view, is influenced by human emotions as it is manifested in authority, property, and group membership. He labels it *interaction ritual chains*. Its main function is to produce and maintain *emotional energy* through *solidarity rituals*, which are in turn influenced by power and status relationships, among other things. Collins argues that for a successful solidarity ritual to occur, a group of at least two individuals should be physically present. Then there should be a focus of attention upon the same object or

activity, and mutual awareness of each other's attention. Finally, individuals must share a common mood (i.e. get caught up in each others' emotions through a common focus and an emotional contagion, driving out competing feelings). As a result of this emotional coordination, feelings of solidarity are produced, which can be divided into the transient, short-term emotions produced in an encounter, and the longer-term feelings of attachment to the group. Collins argues that rituals shape cognition. The shared focus of attention in rituals is loaded with emotional overtones, becoming thereby symbolic of group membership. In order to support his microsociology, Collins (2004) has provided a wide range of examples including sexual interaction, situational stratification and substance ingestion.

Exchange Approach

Followers of this approach perceive human interaction in terms of motivation to obtain reward or avoid punishment. Starting with the work of the well-known behaviourist, B.F Skinner, and developed in sociology by Homans (1961), exchange theory argues that individuals endure costs and make investments in order to receive rewards. The ultimate goal is to receive a profit from interaction with others. Moreover, in every encounter, payoffs are assessed against normative standards of justice and fair exchange that can be determined by such factors as comparison of one's payoffs and costs relative to those of others, previous payoff schedules, expectations for payoff as dictated by norms or past exchanges, and the relative power of exchange partners. When it comes to emotion, the basic principle of exchange theory is that individuals experience positive emotions (e.g. satisfaction, joy, happiness) when payoffs exceed costs and

investments while meeting standards of justice. Conversely, if payoffs fail to exceed costs and investments, namely, if they fall below standards of what is considered fair and just, individuals are likely to experience negative emotions (e.g. sadness, frustration, anger). The nature and intensity of the emotions experienced by individuals vary according to a number of conditions including the type of exchange, the types of structures in which exchanges of resources occur, the relative power and dependence of actors on each other for resources, the expectations for resources, the standards of justice that apply to the exchange, and the attributions that actors make for success or failure in receiving profitable pay offs (Turner and Sets, 2006).

Structural/Relational Approach

In contrast to Hochschild's approach, and as the most important sub-branch of positivism, the structural approach can be described by the work of Theodore Kemper (1978, 1981, 1987), whose theory is deeply influenced by socio-biology, while emphasizing the structural and relational aspects of social relations. Kemper has proposed a well articulated theory of emotions identifying *power* and *status* as two relational dimensions of social relationships around which emotions are experienced. In the core of his theory, Kemper (1978: 32) argues that "a very large number of our emotions result from real, imagined, recollected, or anticipated outcomes of social relationships." Social relationships are themselves determined by arrangements of power and status among interacting individuals. Power includes actions that are coercing, forcing, threatening, punishing, and the like, thereby producing a relationship of domination and control. Status, on the other hand, reflects "the amount of uncoerced, willing compliance,

approval, deference, reward, praise, financial support, even love, that actors accord each other" (1981: 337).

For Kemper, different outcomes in power and status relations activate different physiological processes. Power and status can be described as "triggers" of innate biological processes that produce emotions. In contrast, Hochschild is a proponent of the interactional model, in which feeling rules that she believes influence our emotions are not so much triggers of emotions as they are "zoning regulations," telling us what is appropriate to feel in a given situation. Kemper defines an emotion as a relatively short term evaluative response involving physical and cognitive components. It is different from Hochschild's definition, in which appraisals of a situation lead people to control their emotions according to feeling rules. For Kemper, emotions are rather reactive and transitory, and while they contain cognitive appraisals of the situation, his approach emphasizes how the underlying physiological processes are activated by arrangements of power and status.¹

Given their points of emphasis, I found the above approaches less suitable to study chaplains than those mentioned in chapter one. For example, while a model based on exchange theory emphasizes the reciprocal nature of social interactions, a great number of interactions that take place in healthcare institutions are not exactly mutually interchangeable. In other words, medical professionals provide support for clients, but do not necessarily receive it from clients. That is why in the literature of the sociology of healthcare, medical professionals are sometimes referred to as *care givers* (Davidson,

¹ Another sociologist whose work could be included within the structural/relational approach is Randal Collins. However, given his emphasis on competition and conflict, I categorized him as a conflict theorist.

2007) and patients are referred to as *care receivers*. The relationship can be mutual, but for the most part it is like a one-way road in which healthcare professionals provide support without the expectation of receiving it.

Similarly, the structural approach based on dimensions of power and status does not seem to be a suitable model because a significant amount of the emotions that chaplains experience result from their interactions with patients, who are not usually in a relationship with them that involves power and status. Occasionally and under certain circumstances, chaplains may speak from a power position, demanding their clients to behave in certain ways. For example, in the case of hysterical family members who disturb residents of a hospital floor by sobbing or shouting loudly, a chaplain may take charge of the situation and ask noisy people to contain their emotions until they are directed to a quiet room where they can scream freely without a problem. As we will see, such situations do exist, but they do not represent dominant patterns of interaction between chaplains and clients. I found the above approaches not entirely irrelevant but rather limited in their applicability for the purpose of this study.

Interactional/Symbolic Interactionist Approach

As a moderate version of social constructionism, the interactional approach can be outlined using the work of Hochschild (1979, 1983), who views emotions as manageable and controllable forces, but also looks at them as influenced by human biology. Hochschild calls her approach *interactional* or *normative*. Although mostly influenced by social constructionism, her approach nevertheless benefits from other perspectives by including their useful elements. For example, symbolic interactionism is a proper

approach to describe Hochschild's work as this theory emphasizes the uniquely human capacity for creating, manipulating and modifying symbols to direct one's own behaviour and to influence others' behaviour. According to symbolic interactionists, as role-taking ability develops, one learns to identify and guide emotions in accordance with the meanings they have for other people. Thus, embarking upon the process of socialization with significant others, an individual learns to indicate to the self possible meanings of an emotional expression by imaginatively assuming another person's viewpoint. In this theory, people act towards emotions according to the meanings they impute to them, not primarily in terms of an emotion's biological substructure (Gordon, 1986).

In Hochschild's theory, emotional workers learn to manage their emotions according to the feeling rules and cultural norms of the organization in which they work. In other words, a socialization of emotions occurs according to occupational feeling rules. For Hochschild, emotions possess an interactional character and are produced on the basis of their appropriateness within the situation in which they are experienced. As Hochschild (1979: 560) writes: "we assess the appropriateness of a feeling by making a comparison between feeling and situation," not by abstractly examining the feeling. This comparison provides us with a "socially normal" criterion to infer personal meanings and evaluate the situation, thus allowing us to feel appropriately within that situation.

By emphasizing "feeling appropriately," Hochschild implies that it is essential for people to have a sense of congruency between their aroused emotions in a situation and the norms of that situation. As a result, moving among different situations, people closely and actively evaluate, monitor, stimulate or suppress their emotions to fit the situation. In Hochschild's words, people *work* on their emotions to produce and display those

emotions that are “supposedly” appropriate to the situation. She refers to this process as *emotion work* or *emotion management*. In her view, the first is basically related to private life, and the second to the public sphere (employment). In any case, emotion work is a process whereby not only our emotions are controlled, but also created.

Emotion management includes three basic processes: (1) *cognitive* work, when one changes one’s perspective on the situation to feel differently about it, (2) *bodily* work, when one tries to change one’s physical state by deep breathing or slow movements, and (3) *expressive* work, when one smiles and behaves cheerfully in order to feel happy (Hochschild, 1979). It can also take two different directions: either *evocating* an emotion that does not initially exist but is required within a particular situation; or *suppressing* an emotion that first arises in a situation but must be suppressed and controlled.

Emotion management is an important issue when an emotion is not in line with the situation, namely, when it is not “justifiable” or “legitimate.” In such a situation, people may react in two different ways. Firstly, they may focus on their facial expression and external gestures in an attempt to present a picture of themselves that corresponds to the situation. Hochschild refers to this method as *surface acting*, comparing it to a situation in which emotions are genuinely managed so that they correspond to the outward expression. The second method is called *deep acting*. When she speaks of emotion management in contemporary American society, Hochschild basically means deep acting, in which an emotion is genuinely transformed in order to adjust to the situation. By surface acting, says Hochschild (1983: 25), people deceive others, while deep acting implies self-deception.

A question of crucial importance is how emotion management is directed. People are not entirely free to perform emotion management. In other words, there are certain rules determined by social factors (e.g. culture, civil organizations, business institutions, etc.) telling people how to manage their emotions. Such rules are known as *feeling rules*. A feeling rule is a rule telling us what to feel and what not to feel in a given situation. In a funeral ceremony, for example, one should feel unhappy and display a sad face, while in a wedding, the opposite is the case.

Hochschild (1983) applied her theory to the U.S airline industry, examining how emotion management is performed at the workplace and what consequences it has for “emotion workers.” Borrowing insights from Goffman, Hochschild discusses “appropriate” styles of presentations of self routinely provided in service industries, particularly among flight attendants. But she goes one step further and explains how strategies of emotion management are taught and employed to produce “sincere” presentations. Therefore, she criticizes Goffman for limiting his analysis to outward appearance, ignoring what is going on inside the person. Here lies the difference between Hochschild’s approach and the dramaturgical approach represented by Goffman: Goffman only analyzed surface acting, whereas for Hochschild a substantial part of the presentations of self provided by workers are a result of deep acting.

For Hochschild, emotion management occurs at two different levels: *private* and *professional*. Private emotion management is natural, as people frequently perform it in their everyday lives. In fact, it is a necessary requirement of private life to manage one’s feelings. Professional emotion management, however, is quite different. It is a very problematic endeavour that transfers personal feelings into the public marketplace and

turns emotional work into *emotional labour*. When this happens, emotions become commodities, and their demand oscillates according to the situation of the competition in the industry. Moving from emotion work to emotion labour implies a *transmutation* in the emotional system, by which workers' emotions are appropriated and regulated for organizations' commercial benefit, thereby producing what is referred to in Marxist literature as *surplus value*.

In Hochschild's view, the first important consequence of emotion management at the professional level is the transmutation of emotion work into emotion labour, followed by the misuse of private feelings in the pursuit of profit and/or professional gains. What interests Hochschild is the pressing need to change feelings in a way that fulfills the needs and goals of business corporations. The second important consequence is estrangement of workers from their emotions, which in turn leads to hypocritical and insincere behaviours in service industry. Hochschild argues that with the increase of service work in the airline industry, it becomes increasingly difficult to find genuine personal service. Therefore, workers may avoid the ordeal of emotional labour and offer instead "a thin crust of display," subjecting themselves to a sense of being phony or insincere. In Hochschild's view, the expansion of the airline industry causes flight attendants to manage their emotions through surface acting, rather than deep acting

Hochschild's work has been hugely influential in the literature on the sociology of emotions, and a great number of scholars have used her framework for a wide variety of contexts. For example, Eder and Parker (1987) focused on emotion management and emotion display among cheerleaders. Snyder and Aamons (1993) examined the ways in which baseball players strive for optimum emotional arousal. In the realm of family life

and intimate relations, Seery (1997) studied motherhood and concluded that although being a mother is often pleasurable, it nonetheless means managing distress, anxiety, and relationships. In another study, Paules (1991; in Peterson, 2006) used Hochschild's framework to examine emotion management among waitresses and invented the notion of *autonomous emotional labour*. Cahill (1999; in Peterson, 2006) studied mortuary science students who are required to develop a kind of *emotional neutrality* toward death and suggested the notion of *emotional capital*. Konradi (1996) applied the concept of emotion work in her discussion of rape survivors preparing to give court testimony. More recently, Ducharme and colleagues (2008) studied emotion management among more than 1800 service providers and elaborated on the concept of *emotional exhaustion* at the workplace.

In an interesting study, Schweingruber and Berns (2005) examined how a door-to-door sales company trains salespeople to engage in emotion management. Company managers and salespeople engage in what Schweingruber and Berns name *emotion mining*, that is, "the search for and development of potential emotional capital in workers' experiences that had not been previously recognized by the workers as related to their job"(2005: 681). Managers also make an *emotional bridge*, a process by which newly created emotional capital is used to connect the worker's previous self to the new self that is being developed on the job. According to Schweingruber and Berns, when emotion mining is performed, emotional capital forms an emotional bridge between a salesperson's ordinary self and the self that is supposed to be developed for the job. By way of this occupational emotion management, salespeople manage their emotions in an attempt to develop a new self, which would be more successful on the job.

Although very influential, Hochschild's theory has nevertheless been criticised for a number of reasons. Some sociologists (e.g. Wouters, 1989) have criticised her for overemphasizing the power of organizations, depicting a dark picture of modern American society in which workers are not only emotionally exploited, but also profoundly estranged from their true selves. In reality, however, emotional labour can be satisfying because workers enjoy the sense it gives them of helping their customers or clients. As we will see, hospital chaplains may enjoy emotional labour precisely because of this reason. Several researchers have indeed suggested that in some organizations, workers value their jobs because it provides them with an opportunity to do emotional labour. For example, in a study by Sharma and Black (2001), the researchers concluded that beauty therapists like emotional labour because they are able to help customers feel good about themselves. Similarly, Wharton (1993) found that female realtors like the emotional requirements of their job because it helps customers feel good about their decisions. More specifically, there have been a few studies on flight attendants which show the occupation is not as dark and emotionally terrible as Hochschild implies. According to Wouters (1989), to be a flight attendant is not necessarily a bad job. Flight attendants that Wouters interviewed in the Netherlands, expressed satisfaction with their job as they had ample opportunities to visit different places around the world, stay in luxurious hotels and enjoy good food.

Because of the complexity of emotion management, it is necessary to move beyond Hochschild's early conceptualization and consider different types of emotion management and the different conditions under which emotional labour is performed.

Dramaturgical Approach

Dramaturgy is a sociological perspective rooted in symbolic interactionism. In this approach social interaction is analogous to the theatre and a play. In other words, life is envisioned as a theatre stage: from one door we enter, perform our various roles, and from another door we exit. This view of human life is rooted in a 20th-century philosophy, existentialism, defined by Sartre whose famous maxim was “existence precedes essence.” Existence, according to Sartre, is a series of experiences by which individuals come to experience and perceive themselves; we experience so we exist not vice versa. It is also influenced by the ideas of Kenneth Burke who, inspired by Shakespeare, brought the notion of *dramatism* into social theory. Erving Goffman (1959) was the first sociologist who developed most of the important ideas of dramaturgical theory in his book, *The Presentation of Self in Everyday Life*. Goffman used theatrical language (play, stage, make-up, appearance, manner, etc.) to describe social life and interaction. Though not exactly a sociologist of emotion, he wrote about a diverse range of issues that have important consequences for our emotions. He was a keen observer of social interactions whenever they produce negative emotions, such as embarrassment and shame. His concepts of face-work, demeanour and deference, and presentation of self are particularly useful in discussing different emotions expressed in face-to-face encounters. Moreover, in *Stigma* (1963) and *Asylums* (1961), Goffman extensively explores the world of those unfortunate individuals who are unable to meet standards society sets for its “normal” members, and who therefore experience a great deal of negative emotions.

Goffman views action in a rather different way from traditional symbolic interactionists. For him (1967: 239), action consists of “chancy tasks undertaken for their

own sake.” It is fateful and consequential. Therefore, his major claim, which has been criticized by traditional symbolic interactionist such as Blumer (1972), is that in presenting themselves, individuals are most concerned not with the presentation itself, but with how their presentation is being perceived and what consequences this perception has for their identity. Goffman claims that the self-awareness of how one is being regarded in a face-to-face interaction constitutes the major concern of individuals in handling themselves: “during interaction each person will be at least incidentally concerned with establishing evidence of strong character, and conditions will be such as to allow this at the expense of the character of the other participants; a character contest results; a special kind of moral game” (Goffman, 1967: 240). From this Goffman concludes that while interacting, it is to the benefit of individuals to manage the impression they make on others about themselves. Individuals thus have every motivation to “manipulate” this impression and in many cases, as Goffman shows, do so. Such manipulation of impression can happen via emotional expression. People can use emotions as a vehicle to convey intended meanings and draw desired impressions. For example, Goffman explains how poker players use specific facial expressions to manipulate their rivals, leading them into making false decisions.

Following Goffman, dramaturgical theorists assert that individuals make dramatic presentations and engage in strategic actions in order to influence the situation, directing their own performance, including emotional presentation, and shaping others’ impressions. Actors present themselves in strategic ways, emitting the emotions that are aimed to create a desirable impression. After Goffman, who studied different situations in which people manipulate emotions, Zurcher (1982) provides a dramaturgical analysis of

emotion management among football players. He focuses on how emotional performances are staged in different settings and explains how individuals perform their roles by using different cues and props, and by moving between back stage and front stage. According to Zurcher, the performance of emotion is determined in terms of the appropriateness of emotional behaviour in a particular situation. In other words, emotions are perceived in terms of "contextually appropriate performances." During his participant observations of a college football game, Zurcher realized that football players, coaches and fans are expected to stage different emotional performances according to certain props, cues and rules according to the specific setting in which they are located. For example, when it comes to players, different emotions are to be expressed in the locker room and the field: in the locker room and before the game, players should appear quiet and determined, whereas after the game and in the field, they should express pride and joy if they win. As Zurcher argues, not only is such emotional performance essential for successful social interaction, but individuals are able to shift their emotional display remarkably within a short period of time.

Another sociologist of emotion whose work is influenced by the dramaturgical approach is Clark (1997). Investigating a particular emotion – sympathy – at the micro level, Clark realized that by displaying certain emotional expressions as manipulative strategies individuals are able to gain emotional benefits. In Clark's conceptualization of sympathy, individuals offer sympathy to others in exchange for another valued emotional resource like gratitude. Clark points out that actors manipulate emotional displays in games of micropolitics in order to gain power in an interaction. She argues that the offer of sympathy is often used to establish superiority over those who receive sympathy.

According to Clark, virtually all emotions can be strategically used in this manner because individuals have the capacity for expressive control of their emotions, using the display of emotions to gain advantages over others.

A criticism of the dramaturgical approach is that it tends to look at people as manipulative actors who always express false and phony emotions for the purpose of conning others. Also, most dramaturgical studies overemphasize the external expression of emotions (e.g. facial expressions) and ignore what Hochschild calls deep acting, namely, genuine transformation of emotions according to feeling roles. I will draw on Goffman's terminology to describe the emotion management that chaplains perform on others.

Phenomenological Approach

The term phenomenology is derived from the Greek words *phainomenon* ("an appearance") and *logos* ("word" or "reason"), meaning a "reasoned inquiry" (Madjar, 1998: 28). Therefore, phenomenology can be defined as a reasoned inquiry into the nature of appearances. From another perspective, it can be described as "a study of essences" (Merleau-ponty, 1962; in *ibid*), essence being read as the essential core or nature of an entity under study. The remarkable attribute of phenomenological studies is their primary concern with the study of human experience as it is lived. Consequently, most phenomenological studies within the sociology of emotions emphasize the subjective meaning of emotions and try to link the various ways in which emotions are experienced through perceptions, beliefs, and bodily ways of "being" in the world. As

such, these studies are usually conducted in quite small samples (sometimes less than 10 cases) to obtain a very deep and comprehensive understanding of the phenomenon.

As mentioned in the previous chapter, the phenomenological approach to emotions is presented best in the work of Norman Denzin. For Denzin, self-feelings possess a three-fold structure: (1) a sense of feeling in terms of self-awareness, (2) a sense of the self feeling the feeling, and (3) a revealing of the moral, inner, interactional meaning of this feeling for the self. This enables him to speak about *a circuit of selfness* by which not only is the self linked to the world, but our emotional experience or emotionality is produced. As Denzin argues, emotionality is experienced not in the self or in the body, but rather in the relationship that one has with one's self and with one's lived body. The body as experienced is not captured in a range of physiological sensations, but in meanings that one receives in one's network of interactions. Given the importance of interactions, Denzin concludes that lived feelings communicate an emotional definition of the situation that others can enter into, and by doing so, move their emotionality out of the private, inner world of pure sensations into the public realm of interaction and emotional intersubjectivity. As a result, one can communicate and share feelings with others, thereby allowing them to enter into one's field of emotional experience. Denzin's approach to emotion as lived experience is indebted to phenomenology, symbolic interactionism and existentialism. He applied his approach to the film industry to explain how Hollywood shapes and influences our emotional experience as it is lived in the body.

For Denzin emotion is a *practice* that produces an expected or unexpected emotional alteration in the inner and outer streams of experience. It is gender specific and is influenced by gender ideologies. One way to have our emotionality (the process of

being emotional) influenced by gender stereotypes is to watch films. As Denzin argues, Hollywood plays a tremendous role in shaping post-modern emotionality. It is through movies that we understand ourselves and others, giving meaning to the inner worlds of our emotional experience. In Denzin's judgment, human emotionality is shaped by the web of human relationships that binds humans to each other. To understand emotions, one can simply focus on cultural and gendered patterns of interaction presented in movies as "culture-making institutions." Movies determine "ideal" styles of emotionality and intimacy. They create an emotional relationship with the viewer and formulate his or her ideological attitudes towards love, desire, sex, intimacy, work, family, marriage and emotionality. Through movies, gendered conceptions of love and sexuality are first defined and later lived. Hollywood presents ideal patterns of intimate relationships between men and women, thereby providing cultural representations of gendered intimacy.

Denzin argues that to understand modern emotionality, one should take into consideration the historical and cultural trends that American society went through after the postmodern, postwar period. In particular, specific attention should be paid to: (1) commodification of human desires, (2) bureaucratization of human roles, (3) deconstruction of human myths, and (4) mass mediated reality. These are basic processes through which dominant modes of emotionality and emotional experience are produced and sustained in post-modern society. They indicate the political economy of postwar, late capitalist America.

Denzin's ideas are useful in that they allow us to see how emotional experience can be viewed from a perspective much different than that of Hochschild. His emphasis

on cultural domains, and on the Hollywood film industry in particular, is indicative of new transformations in emotional experience as a result of unprecedented change in modern contemporary society. Recent developments in new technologies and tools of communication have influenced all aspects of human life, including emotions.

Several researchers have specifically examined emotion management from a phenomenological perspective. For example, Almarza (2008) explored the lived experience of adult children living at home with a parent who has been diagnosed with, and treated for, cancer. Using an interpretive phenomenological approach, Almarza realized that such adult children experience intense and distressful emotions such as fear, anger, shock, and helplessness. Also, treatment was described as a “turbulent time,” of multiple demands and of heightened emotional distress. Yet, despite the suffering, participants also drew constructive meaning from their experiences. They highlighted the crucial need to talk to someone.

In another study, Spencer-Carver (2008) employed a phenomenological approach to interview mental health professionals who worked with children who experienced the death of a parent from intimate partner violence. According to the researcher, the difficulty of providing care and support for such children extracts a toll on the physical and mental health of caretakers. Caretakers interviewed by Spencer-Carver needed to provide emotional as well as physical care. When emotional support was available, children were able to tell the story of their experience, which they needed to do over and over again. The most problematic situations that participants described were with children who had not discussed this life event ever since it had occurred. These children

did not explore their feelings about the death of their parent or share what the loss meant to them with others.

Given the significance of lived experience in phenomenological investigations, my research can be said to be influenced by phenomenology, in that the intention is to understand emotion management as it is experienced by chaplains. Phenomenological studies attempt to penetrate the core and center of phenomena under study. My goal is to provide a phenomenologically rich description of emotion management and different ways through which chaplains' emotionality is experienced.

Ethnomethodological Approach

By analyzing accounts and descriptions of day-to-day experiences, ethnomethodology attempts to understand the social orders people use to make sense of the world. An ethnomethodological approach assumes everyday practical reasoning is the basic constitutive element of all human activities. This approach is informative for understanding emotions especially when the assumptions with which people make sense of their lives cease to function or when people find innovative, context-specific ways to perform emotion management. As the founding father of ethnomethodology, Garfinkel (1967) argues that a person's cognitive capacity is limited. As a result, people rely on some basic assumptions to make sense of their everyday lives, and perform their roles. For example, a man expects his wife not only to recognize him as her husband, but also to interact on the basis of this recognition, as opposed to acting as if they are absolute strangers. Unless such assumptions are disturbed, routine, everyday life continues without any problem. But if they fail to function, life becomes chaos, society loses order,

and interaction becomes impossible. In a series of experiments known as “breaching experiments,” Garfinkel did actually challenge some of the basic assumptions regarding the ways in which people make sense of life, demonstrating how vulnerable and problematic the structure and order of society are if regulations around which interactions and interpersonal relations revolve are interrupted. Garfinkel invented a diverse range of notions (e.g. indexicality, reflexivity) to emphasize the emerging, contextual, innovative and reflexive nature of social structure. For example, he examined how people take for granted their reliance upon the existence and use of descriptive vocabularies for handling bodies of information and activities, where the vocabularies themselves are constituent features of the experiences being described. As Garfinkel (1976) puts it “the vocabularies are an index of the experience.” But the experiences, in the course of being generated or transformed, acquire elements of the vocabularies as part of the generative process and permit the retrieval of information indexed by selected elements of the original vocabularies. Garfinkel used catalogues in libraries as an example of this reflexive feature of practical reasoning. Such assumptions or practical reasoning, with which not only do we make sense of life but also reproduce order and the structure of interaction, lead to what Garfinkel calls “an ongoing accomplishment.” By breaking these assumptions, a diverse range of emotions (e.g. surprise, fear, anxiety, embarrassment, etc.) can be produced.

As an example of the ethnomethodological approach to emotion, we can look at Bolton and Boyd’s (2003) study in which emotion management is examined among the “cabin crew” of three UK airlines. These researchers believe Hochschild’s concept of emotional labour is ultimately “absolutist” in its implementation and consequences

(2003: 290). In their view, emotions within organizations cannot be simplified and condensed into one category. They criticise Hochschild for overemphasizing the division between public and private types of emotion management, and offer instead an elaborate analysis of emotional labour and alternative types of emotionality in the airline industry. Emotion management, argue Bolton and Boyd, can take four distinct types: (1) *pecuniary*, (2) *presentational*, (3) *prescriptive* and (4) *philanthropic*. While the first two are similar to Hochschild's concepts of emotional labour and emotion work, the next two are indeed different and additive. Prescriptive emotion management is a kind of management in which one may follow feeling rules, but not necessarily in terms of a cost-benefit analysis. Philanthropic emotion management is a kind of management in which not only may one decide to follow a feeling rule, but one may decide to do it more than enough, in the sense that one may become too concerned with providing a desirable service. Flight attendants that were studied by Bolton and Boyd performed all of these types of emotion management. They are able to work in "potentially unmanaged spaces" where it is possible to interpret, manipulate, and implement the managerially prescribed rules of feeling.

The above study explains how Hochschild's work can be criticised from an ethnomethodological point of view as it emphasizes how flight attendants can play, in diverse and innovative ways, with everyday, routine occupational feeling rules in their workplace and thus experience emotional labour in ways that differ from Hochschild's analysis.

Emotional labour, therefore, can be viewed from an ethnomethodological perspective. In a study conducted about beauty models, Mears and Finlay (2005) wanted

to know whether models must do emotional labour or if they only needed to rely on their “bodily capital.” Interestingly enough, they found that while models rely heavily on their physical attractiveness to enter the job, they nevertheless have to learn how to perform emotional labour without being explicitly told. For example, models may have to engage in “strategic friendliness” (Mears and Finlay, 2005: 319) as a form of emotional manipulation of others to achieve a desired outcome. Again from an ethnomethodological perspective, we can see that such “strategic friendliness” is indexical as it is dependent for its sense upon the context in which it is embedded. As Mears and Finlay explain, models regularly express deference (e.g. in terms of “schmoozing”) toward those who control access to castings and job-agents, bookers, and clients. Expression of deference in this context is not because models like the above agents but because they want to secure employment. In contrast to Hochschild’s argument, this kind of emotional labour is not scripted or performed under the authority of managers or supervisors. Such an ethnomethodological approach to emotion management helps us understand how workers may perform emotion work in relation to the context and in innovative ways.

Several different versions of ethnomethodology have been developed after Garfinkel. In fact, an orthodox reading of ethnomethodology looks at social structure as an illusion of the sociologist’s common sense knowledge unless he or she can reveal a connection between the cognitive processes that contribute to the emergence of contextual activities and the normative accounting schemes people use for claiming knowledge (Cicourel, 1973). Following Garfinkel, a number of ethnomethodologists (e.g. Sacks, Cicourel, and Schegloff) became interested in conversation analysis and the use of language in social interaction. For these ethnomethodologists, a basic consideration in the

study of practical reasoning is the use of everyday talk or accounts used to describe the factual status of their experiences and activities. Therefore, a central concern is the study of peoples' necessary reliance on practical or mundane reasoning to communicate with others. They study talk as produced and understood in indexical displays of the everyday world (Garfinkel, 1967; Cicourel, 1973). In this regard, Cicourel (1973) invented the concept of *interpretive procedures* by articulating ideas from phenomenology, ethnomethodology, work on language acquisition and use, memory and attention, and information processing, to explain how language and meaning are reproduced in social interaction. According to Cicourel (1973: 99), the structure of language relies on practical reasoning as a tacit and unexamined resource for finding in talk an innovative but rule-governed structure (competence) that transcends actual display (performance). Described as *interactional competence* (Cicourel, 1973: 164), this process pinpoints the relation between cognitive processes, contextual emergence, and vocabularies of language used to create socially meaningful communication. It also reveals a connection with the cognitive processes that contribute to the emergence of contextual activities.

As we will see in the following chapters, an essential component of every chaplain-patient relationship is the ability to create effective communication by both verbal and non-verbal means. Chaplains attempt to find innovative ways to initiate conversation and effectively communicate with emotionally distraught patients. In Cicourel's language, they need to be armed with interactional competence in order to perform their jobs efficiently. Successful communication leads to an ongoing accomplishment of confirming the chaplains' role as spiritual care providers, while lack of such success leads to the experience of negative emotions such as frustration and

sadness. I will use these ethnomethodological concepts to discuss issues of communication and interaction between chaplains and their clients.

After reviewing the important theoretical approaches that inform the theoretical framework of this study, I will now discuss emotion management in a healthcare context. Hospital chaplains, after all, are healthcare professionals.

Emotion Management in Healthcare and Medical Context

Beginning with the work of Peter Freund in the 1990s, a number of studies attempted to connect the sociology of emotions with medical sociology, concentrating on the relationship between emotion management and health. Inspired by Hochschild, Freund (1990,1997) offered an influential concept according to which the ways one presents oneself in front of others are emotionally consequential: if they fail to fit with the situation in which they are presented, one is likely to experience what Freund calls *dramaturgical stress*, namely, a tension resulting from a “profound disjuncture between the ways in which one desires to present oneself and the social context which demands an ‘opposite’ style of self-presentation and does not allow the actor to leave the field” (1997: 276).

While dramaturgical stress is the result of emotion management, it nonetheless depends on one’s place in the hierarchy of the organization. Drawing on Hochschild’s (1983) concept of *status shields*, Freund examined how social position affects dramaturgical stress and the health of the individual. He brought this concept into medical discourse and suggested that high-status persons experience less dramaturgical stress than low-status persons. From this it can be argued that people’s health is related to

the degree of dramaturgical stress they experience based on their social position within the organization in which they work.

Moving beyond Freund's concept of dramaturgical stress, several scholars have studied emotion management in healthcare institutions to consider different aspects of it. For example, Francis (1999) and her colleagues explored the use of humour as an emotion management strategy to combat unpleasant emotions resulting from stressful situations. Meerabeau and Page (1998; in Francis, 2006) studied the emotion management methods that nurses employ in order to distance themselves from dead and dying patients. According to these scholars, the academic curriculum with which nurses learn to perform their jobs is incompatible with the realities and the "messiness" of nursing practice: nurses sometimes find themselves in situations that force them to feel inappropriate, ineffective, or even ludicrous because of what they have to do as part of their job.

As a prolific sociologist of emotions, Peggy Thoits (1990, 1996) has extensively researched emotion management in different contexts, including healthcare. Her focus is not only on self emotion management, but also on managing the emotions of others. And not only has she provided typologies of different strategies and methods of emotion management, but she also coined the term *emotional deviance* to refer to an event in which individuals are unable to reconcile themselves with the feeling rules of the situation. The concept has proved influential in the study of emotion and mental health. Thoits has studied emotion management among different categories of people, including college students and various support groups. In one study (1990), she took Hochschild's four-factor definition of emotion and added to it the argument that changing any one of

the factors should dampen or alter the feeling experienced itself. By arguing that individuals can use either a behavioural mode or a cognitive one to alter their emotions, Thoits was able to create an eight-fold classification of emotion management techniques including, among others, leaving the situation, catharsis, taking direct action, seeking support, hiding feelings, and seeing the situation differently. In another study, Thoits (1996) examined a psychodrama-based encounter group which deliberately manipulates its members' feelings. Here she discovered different strategies of emotion management including lone and group enactments, provocations, physical-effort techniques, and comforting.

Thoits argues that different organizational settings require different strategies of emotion management. A military organization, for example, is different from a medical one. But they share one fundamental characteristic: a pressing need placed upon individuals to align their emotions with organizational requirements.

In contrast to Hochschild, who was primarily concerned with self emotion management, Thoits paid special attention to managing the emotions of others. This kind of emotion management, known as *other-focused or interpersonal emotion management* (Erickson and Grove, 2008), is particularly important for those working in healthcare institutions, including chaplains, whose job is to provide care for patients by helping them cope with and manage their emotions. Although such service delivery may require that care providers manage their own emotions as well, interpersonal emotion management emphasizes the facilitation of others' emotion work. This is in contrast to another version of interpersonal emotion management, known as *reciprocal emotion management* (Lively 2000), in which interpersonal emotion management is performed

with the expectation that, over time, others will do the same for oneself. In medical institutions, such expectations are not usually a part of the relationship between care provider and patient. As we will see, the chaplains' main role is to perform interpersonal emotion management. Consequently, in their professional training, skills and techniques of this type of management are specifically emphasized.

Applying the idea of interpersonal emotion management to interactions between patients and physicians, DeCoster (1997) introduced the concept of *emotion treatment* to refer to the management of patients' emotions performed by physicians as part of their professional role. DeCoster identified several strategies that were used by physicians to try to shape and control patients' emotions. Interestingly enough, DeCoster found that a considerable number of strategies employed in patient-physician interactions require ignoring the patient's expressed emotion. In a similar study by Waitzkin (1991; in Heritage and Maynard, 2006), the conclusion was that the underlying structure of medical discourse bans physicians from expressing personal emotions. Such findings are in contrast to another group of studies on physician-patient relationships in which the importance of physicians' emotion management on patients' well-being is specifically highlighted. However, there seems to be no concern with the impact of such management on the well-being of physicians. Baker et al. (2003), for example, suggested that physicians' emotional expressiveness increases patients' well-being and confidence. Also, Lupton (2003) studied the importance of expressing trust and argued that lack of trust in the physician-patient relationship leads to patients' increased fear, vulnerability and uncertainty. The above examples indicate that more research is needed to obtain a better understanding of interpersonal emotion management in medical institutions:

studies such as DeCoster (1997) and Waitzkin (1991) indicate that physicians are expected to appear emotionally detached, whereas studies by Baker et al. (2003) and Lupton (2003) arrive at precisely opposite results. This indicates that emotion management in medical institutions is complicated and that normative expectations are not consistent, giving rise to contradictory feeling rules.

Emphasizing the increasing complexity of today's healthcare organizations, Bolton (2000) argues that beyond the technical task of managing their emotions, healthcare professionals need to rely on their ability to create a "correct emotional climate:" not only should they work hard on their own emotions in order to present the detached face of a professional caregiver, but they should also offer authentic service to patients under their care. Bolton and Boyd (2003) later elaborated on this by differentiating nurses' emotion management in terms of the feeling rules governing their behaviour and the nurses' underlying motivations for their performance. In society, these authors argue, people generally expect that physicians and nurses approach healthcare with a certain level of empathic concern. Within medical schools, however, these expectations are likely to be contradicted by professional standards of behaviour and treatment. As previous examples show, this can be a problem in the case of physicians who are taught, in medical school, to be emotionally detached, yet beside the hospital bed they may be expected to display care and concern. Such a tension, created by the need to balance two opposing sets of feeling rules, represents one of the unique factors influencing emotional labour within medical institutions. Given the nature of spiritual care, which often uses emotions as a vehicle to establish spirituality, I assume this tension is more acute among hospital chaplains. Considering the fact that chaplains provide

emotional support, obtaining a “correct emotional climate” should be at the forefront of their priorities. As we will see, some chaplains are likely to feel this tension in relation to other medical personnel (e.g. nurses) who expect them to always be ready to provide emotional caring.

Healthcare professionals encountering this tension may experience what Rafaeli and Sutton (1987) term *emotional dissonance*, which occurs when feeling rules are inconsistent with the emotions actually experienced. Rafaeli and Sutton suggest that while dissonance tends to lead to emotional labour, its potential effect on well-being depends on the extent to which individuals see the rules as appropriate for the occupational setting or professional role. In other words, emotional dissonance is related to the level of congruence between a care provider’s personal or professional values, and the role requirements specified by the employing organization. For example, to the extent that a nurse has internalized the importance of not displaying fear or disgust in front of patients and their families – even if she is actually experiencing these emotions – she will fake the expected emotion in “good faith” (Rafaeli and Sutton 1987: 30). It should be noted that emotional dissonance is different from Thoits’ notion of emotional deviance in the sense that dissonance leads to the performance of management strategies that will bring the expressed emotion in line with surrounding norms, whereas emotional deviance takes place when an individual does *not* engage in management but continues to feel and express an emotion that is not compatible with the feeling rules of the situation.¹

As the above arguments indicate, emotion management in medical institutions can be complicated and challenging; it can affect workers’ health negatively, and put

¹ Emotional deviance can also happen when the individual does perform emotion management but the result is not successful. Failure to perform emotion management may result in what Copp (1998) calls occupational emotional deviance.

obstacles in the way of the provision of care, ultimately undermining the healthcare system. It is important to discuss these consequences under a separate section as I do below.

Consequences of Emotion Management for Healthcare Professionals

1. Stress and Distress

There is a large body of research on the impact of emotion management in nursing, specifically as a gendered occupation, that explores the relationship between nursing skills and traditional female qualities (Gabe et al., 2004). Emotion management for nurses can be either a burden or a resource for dealing with occupational demands, or a combination of both. In some studies, how nurses become engaged in emotional labour to meet the structural demands of employment is under investigation; in other studies the focus is on how emotion management is used as a tool to generate more control and power among the less powerful actors in the work environment (Francis, 2006). In her research on emotion management in nursing, Francis (2006) specifically emphasized the intensity of stress that nurses go through.

Stress has been a particularly interesting topic in the literature of the sociology of health and illness. Defined as a phenomenon that “occurs when an organism must deal with demands much greater than or much less than the usual level of activity” (Clarke, 2000: 146), stress can be useful when it functions as a means of adaptation to an environment. However, too much stress can be overwhelming, leading to serious illness or even death. Social factors that produce stress are usually referred to as *stressors*. Stressors such as divorce, marital separation, immigration, or a jail term can negatively

affect the health and well-being of the people who must deal with them. In fact, the greater the number of stressors, the higher the probability of becoming vulnerable to disease and emotional dysfunction. When Statistic Canada conducted a social survey in 1992 and asked several questions about stress-related issues, Canadian citizens who had more social responsibilities were among those citizens who suffered the most from different stresses. For example, mothers of infants and workers with compressed work-weeks and with on-call work were likely to be stressed continually (Clarke, 2000: 153).

Copp's (1998) study of emotion management among service workers at a shelter workshop for people with developmental disabilities is a good example to explain the multiple consequences of emotion management, including stress, among healthcare professionals. Like Thoits, Copp is also concerned with how people manage the emotions of others. Copp (1998) examined emotion management among service workers to see what happens when they struggle to manage their emotions under conditions that "doom them to fail." She realized that even though these workers are frequently overwhelmed with emotional problems, the occupational feeling rules of their workplace require that they ignore and suppress negative emotions. As a result, they inevitably experience what Copp calls *acute distress*. If they continue under such circumstances for a long time, acute distress turns into *chronic stress*, in which the individual's capacity to perform adequately in social roles will be damaged. Moreover, workers who repeatedly fail to manage their emotions experience another problem that Copp (1998: 316) refers to as *occupational emotional deviance*, namely, the "cumulatively detrimental influence of the workplace on workers' abilities to adequately manage their emotions and perform their jobs." Yet most of these workers, according to Copp, are able to survive on the job

because they are attached to specific emotional ideologies. One such ideology is reflected in their view towards the job: they see their job (helping mentally disabled persons) as a meaningful and valuable way to have a positive effect on others' lives. This enables them to feel good and continue their job by re-framing their definition of the situation and focusing on the positive points.

2. Burnout

Being subject to persistent stressors can cause *burnout*, a common phenomenon among some medical professionals that stems from long-term exposure to stressful or emotionally demanding situations. More than any other concept, burnout has been quantitatively studied among different categories of medical professionals as one of the most common consequences of intense care-giving work. For example, in a study by Gary et al. (1988), burnout was examined among a sample of 562 licensed, doctoral-level, practicing psychologists in the U.S. A. The result of the study indicated that more than a third of the sample reported experiencing high levels of both emotional exhaustion and depersonalization. The typical burned-out psychologist in this study is young, engaged in little individual psychotherapy, has a low income, experiences feelings of lack of control in the therapeutic setting and feels overcommitted to clients.

The most frequently used instrument to measure burnout is the one designed by Maslach et al. (1986, 2001). In one categorization, it consists of three basic dimensions: emotional exhaustion (feeling emotionally drained and overwhelmed by work), depersonalization (emotional withdrawal from work), and a negative view of one's personal accomplishments and contributions in one's work (Wharton, 2009). In my study, burnout is measured not by quantitative instruments, but by verbal explanations by

chaplains who, for example, find themselves reluctant to work or visit with patients.

Adapting a phenomenological approach, I try to understand how chaplains explain burnout as it is lived and experienced in the body.

3. Compassion Fatigue

Another health problem that threatens medical professionals is compassion fatigue. This is especially relevant to those professionals who work with critically ill patients or victims of traumatic events (e.g. emergency personnel, fire fighters, etc.). Given the nature of their job, chaplains are also likely to suffer from compassion fatigue. Unlike burnout, which is related to chronic tedium in the workplace and has an accumulating nature, *compassion fatigue* results specifically from interacting with trauma victims and is thought to be the direct consequence of being compassionate and empathetic towards those who are struck by a tragic event (Taylor et al., 2006). Researchers found that one in five people who are victimized in a violent crime (e.g., rape, attempted rape, robbery, aggravated assault) seek help and support from one kind of therapist or another (Flannelly et al., 2005). Compassion fatigue is the emotional cost of working with such victims. As a matter of fact, the diagnostic and statistical manual of mental disorders defines *Acute Stress Disorder* and *Post Traumatic-Stress Disorder* as existing in anyone who has “witnessed or has been directly confronted with an event that involves actual or threatened death or serious injury, or is a threat to the physical integrity of oneself or others”(Figley, 1995:14). The risk of trauma also involves those who are in a relationship with a person who was directly exposed to a horrific event. This kind of traumatization, sometimes referred to as *secondary traumatization* (Figley, 1995), or *vicarious traumatization* (Stamm, 1999), includes three major risk factors for individuals who are

in contact with trauma victims: (1) exposure to the stories of multiple disaster victims, (2) empathic vulnerability to the suffering of others, and (3) unresolved emotional issues that relate to the suffering of the survivors (Figley, 1995).

Secondary exposure to trauma can lead to the development of a chronic condition in which work seems to take over a person's sense of self. Over a period of time, a person can become unable to find a balanced sense of perspective. Paradoxically, a person can reach a state in which they are exhausted, but unable to slow down. At such times, an individual is especially vulnerable to distressing thoughts, unpleasant memories, or disturbing flashbacks. It can be also accompanied by a condition in which a person stays constantly on guard, anticipating danger at every turn.

The above discussions explain the importance of studying emotion management among medical professionals. Whether it be interpersonal or self-oriented, emotion management can cause serious problems, including, among others, burnout, compassion fatigue, chronic stress and acute distress. Different and conflicting feeling rules can also further complicate emotion management, and expose some medical professionals to emotional deviance and emotional dissonance, undermining their efforts to sustain a balanced emotional climate. All of these issues make medical personnel important cases for studying emotion management. I now turn to hospital chaplains as a category of healthcare professionals that has been neglected in previous research on the negative consequences of emotion management.

Hospital Chaplains as Healthcare Professionals

Religion can influence health in both positive and negative ways. For example, being angry with God after a terminal diagnosis, or an inability to make sense of intense suffering, can further intensify a health problem. On the other hand, strong faith can help people cope with sickness and pain (Koenig et al., 1998; Pargament et al., 2000).

Hospital chaplaincy seems to be an important factor in patient's religiosity and spirituality, as the patient's health can be influenced in positive ways. One role of chaplaincy is to identify emotional problems related to religious values and try to reconcile them. This is especially important because the science of medicine has become increasingly secular. As medicine began to expand at an unprecedented rate from the early 19th century, religiously charged institutions that were traditionally responsible for providing medical service were gradually replaced by professional, more secular, medical institutions. While medicine has become more efficient and effective, at the same time it has developed an impersonal approach toward the patient, viewing him or her as a machine. Physicians are criticized for losing the kind of compassion and empathy with which they used to treat patients. They are taught to become emotionally detached and objective. Physicians in modern, highly technical hospitals, says May (1993), have less time to spend with individual patients. Their previous roles as attentive healers are changed as they become highly educated technicians, whose relationships with patients are contractual and where legal and ethical boundaries are established through the influence of a huge, impersonal, anonymous mass society that delivers healthcare to strangers and often in the context of total institutions.

In her book *From Detached Concern to Empathy: Humanizing Medical Practice*, Jodi Halpern (2001) explains that modern medicine supports detached concern over emotional expression. Detached concern is the ability to remain empathic toward an individual, while at the same time putting distance between oneself and the patient in order to remain objective. Before 1910, says Halpern, physicians equated emotionality with medical practice. However, as time passed and modern medicine developed, physicians were urged to employ emotional detachment when working with patients. Consequently, medicine became rooted in what Halpern (2001: 131) calls “masculinized conceptions of scientific objectivity and emotional neutrality.” Several studies (e.g. DiLalla et al., 2004; Fox, 2006) have demonstrated that medical students’ ability to empathize with their patients diminishes as they advance through their medical education, a point well explained by Goffman few decades ago: “idealistically oriented beginners in medical school typically lay aside their holy aspirations for a period of time. During the first two years the students find that their interest in medicine must be dropped so that they may give all their time to the task of learning how to get through examinations. During the next two years they are too busy learning about diseases to show much concern for the persons who are diseased. It is only after their medical schooling has ended that their original ideals about medical service may be reasserted” (1959: 20-21).

In response to the domination of this kind of medicine, which seems to be highly technical but lacking sensitivity, hospital chaplaincy gained momentum. Moreover, medical settings are excellent places for theological reflection, since they are places where people come face-to-face with their vulnerability, and ultimately, their mortality. As such, they are places of anguishing ambiguity, with hope and healing waiting at one

side, and terror and tragedy threatening the other. As Gibbons and Miller (1989) argue, hospitals are places where severe challenges to the human spirit are everyday occurrences, where faith in all its meanings is tested.

As a result, religious agents still continue in diverse ways to address the spiritual needs of people who, for any reason, come to medical settings. As an integral part of the healthcare system, hospital chaplains have become increasingly professionalized (Cadge, 2009), meaning that they can be trained and employed by hospitals in full-time jobs as spiritual care providers. According to a survey by Cadge and colleagues (2008), between 54% and 64% of hospitals had chaplaincy services between 1980 and 2003 in the United States. It is estimated that more than 10,000 professional chaplains work in American hospitals.

The first clinical training of hospital chaplains occurred in 1925 when four students of theology enrolled with a clergy man named Anton Boisen for a summer of study at Worcester State Hospital, a hospital for mental disorders in Massachusetts. They began to work with patients as attendants, read, and attended seminars in order to provide spiritual support for patients (Stokes, 1985). Therefore, the first training in what is now recognized as Clinical Pastoral Education (CPE) was performed at a mental hospital. Later, pastoral training was conducted at general hospitals, prisons, and social agencies as well. Not surprisingly, it was easier for women to become hospital chaplains than parish ministers, who were traditionally male.

In 1969, the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) provided guidelines for religion and spirituality in hospitals for the first time. In 2003, JCAHO declared that medical services should be offered in such a way that

patients' personal, cultural, psychological, and spiritual values would be respected. As a consequence, hospitals are required to demonstrate respect for patients' needs, including the need for pastoral care and spiritual support (Cadge, 2009). To improve their medical services, hospitals conduct a test called the spiritual assessment test to determine how the religious or spiritual perspectives of a newly admitted patient may affect the care he or she receives. In order to conduct this test, they also have specific instruments known as spiritual assessment tools.

Today, hospital chaplains deal with a wide range of issues including religious and spiritual values, dietary options, pain concerns, end-of-life issues, and the treatment and responsibilities of medical staff (e.g., do the medical staff respect a patient's religious values?). Their daily work may include providing "emotional, practical, ritual and crisis intervention services to patients, families, and staff individually or as members of health care teams" (Carey, 1973; Bassett, 1976; Barrow, 1993; Rodrigues et al. 2000; Flannelly et al. 2005; Sakurai, 2005; in Cadge, 2009: 843).

Chaplains make daily rounds in different wards of the hospital and are available at all times to provide pastoral care for both religious and non-religious people. When it comes to religious patients, hospital chaplains can see patients before their minister is aware of the hospitalization. Chaplains provide pastoral support which is often involved with emotional support, until a patient's own minister arrives. In large hospitals, chaplains may provide seminars and workshops on topics such as patient visitation, terminal illness, death and dying, and the grieving process. Chaplains are also available to help the families of critically ill or dying patients. If patients do not have their own

minister, chaplains could serve as such to provide emotional comfort in moments of crisis.

While the concept of chaplaincy is reminiscent of religious and pastoral support, in recent years the scope of its service has gone beyond strictly religious concerns. The most important element of chaplaincy training, which is based on the CPE model, represents the emergence of a secularized professional practice from a religiously-based theological practice. The transformation of hospital chaplaincy into “spiritual care services” is one example of how religious ministry can become modernized, navigating its way through different forms of secular medicine and the pluralism of the contemporary healthcare system. The word “spiritual” is a label strategically deployed to extend the realm of relevance to any patient’s “belief system,” regardless of their religious affiliation. Likewise, “theological language” is recast as a tool for conceptualizing “spirituality.” Such changes transform chaplaincy from a peripheral service, applicable only to the few “religious” patients, into an integral element of patient care for anybody who needs it (Craddock Lee, 2002).

In a study by Flannelly et al. (2005a), a random sample of hospital administrators was surveyed about their views on the importance of chaplains’ roles and functions. Interestingly, while the majority of respondents considered chaplains’ roles to be relatively important, meeting the *emotional needs* of patients and relatives was seen as chaplains’ *most important* role, whereas performing religious rituals and conducting religious services were seen as *least important*. More specifically, providing end-of-life care, praying with patients and relatives, and providing emotional support to patients, family members and friends were rated highly. Performing religious rituals and

conducting religious services were consistently rated the lowest in importance. In a similar study by Weiler (1975) about patients' evaluations of chaplains' roles, over 600 patients from eight Christian denominations were asked to rank seven chaplain roles in terms of their importance. The seven categories were: (1) friendly visits, (2) visits before surgery, (3) bringing the sacraments, (4) chapel services, (5) support for relatives, (6) counselling and (7) comfort. The results of this study also show that friendly visits ranked the highest, followed by providing comfort and visits before surgery. Overall, chapel services were ranked the lowest, and bringing sacraments was close to the bottom, except for Catholic and Lutheran patients, who ranked it first and third, respectively.

The above studies are interesting examples that show how chaplaincy has changed from a ritualistically performed practice to a more emotionally charged, care-giving service. As a result, chaplains can be subject to the multiple consequences of emotion management discussed in the previous section. Chaplains encourage people to talk about themselves and their experiences in order to make a connection between self and internal feelings. The role of chaplains is to help people make that connection, developing thereby a spiritual and/or meaningful approach toward life. Professional chaplains, thus, are skilled in eliciting stories that evoke self-understanding. In most public hospitals, chaplaincy does not necessarily involve religious discussions or the use of religious terms. The focus of chaplaincy is on relationships and counselling, and the service is offered to anyone, regardless of who they are, or what kind of religious attitude, if any, they hold. In fact, in some hospitals, effective communication among medical personnel and patients is mainly facilitated by chaplains, who are considered fundamental to the achievement of successful healthcare delivery (Schnell, 2003:109).

The most significant document explaining the work and role of chaplains is a paper prepared by the five largest healthcare chaplaincy organizations in North America. This paper, edited by VandeCreek and Burton (2001) and published in a volume of *The Journal of Pastoral Care*, describes the role and significance of spiritual care and is the first joint statement on hospital chaplaincy prepared by The Association of Professional Chaplains, The Association for Clinical Pastoral Education, The Canadian Association for Pastoral Practice and Education, The National Association of Catholic Chaplains, and The National Association of Jewish Chaplains.

According to this document, professional chaplains use their specialized education to mobilize patients' spiritual resources so that patients can better cope with their health problems. Because people are likely to turn to spiritual resources during illness and other painful experiences, professional chaplains are specially trained to encourage religious coping mechanisms. They provide a supportive context within which patients can discuss their concerns. They should be empathic listeners, demonstrating an understanding of the patient in distress.

There are several studies on hospital chaplains (see, e.g. Cadge, 2009). Some of them examine the relationship between patients' visits with chaplains and their satisfaction with the overall hospital experience, while others attempt to describe how chaplains work differently with different populations, depending on the age of the patient, severity of illness, religious/spiritual tradition, and presence of family. The majority of such studies have been conducted in the United States, especially in various hospitals in and around New York City, and most of them are quantitative. However, in Canada only a few studies of hospital chaplaincy can be found. For example, O'Connor et al. (2005)

studied the perceptions of Canadian chaplains of spiritual assessment tools. Using both quantitative and qualitative methods, O'Connor et al. (2005) conducted research and found that published spiritual assessment tools are not well known among Canadian chaplains. These tools are used little, and are criticized for being reductionist, and unable to fit the clinical situation. Chaplains who were interviewed by O'Connor and his colleagues actually developed and relied upon their own spiritual assessment tools to measure the spirituality of their patients. In another study by O'Connor and Meakes (2008), the sources and definitions of theological reflection in pastoral care were investigated. By interviewing a sample of seventy-five Canadian chaplains, these scholars realized that the main sources of theoretical reflection in pastoral care are sacred texts, personal experience, experiences of clients, and traditions of faith groups. Likewise, the main definitions are meaning-making, discovering the divine, and discipleship.

None of these studies are specifically concerned with chaplains' well-being and mental health, or how they manage their emotions on the job. A few studies I was able to find in this regard are either related to chaplains of other countries (e.g. U.S.A.), or clergy and religious authorities in general. For example, Taylor et al. (2006) studied a sample of 66 female and male rabbis of the United States who were working as hospital chaplains, focusing on compassion fatigue, compassion satisfaction, and burnout. On average, the chaplains in that study exhibited a low level of compassion fatigue and an extremely low level of burnout. They had, as Taylor and colleagues argue, a "good potential" for compassion satisfaction. Compassion fatigue was higher among women and individuals who were divorced, and it increased with the number of hours per week that chaplains spent working with trauma victims or their families. Burnout was also higher among

divorced individuals. Burnout decreased significantly, and compassion satisfaction increased significantly with age. By utilizing regression analysis, Taylor and colleagues discovered several professional and personal variables that influenced compassion fatigue among chaplains. Among the professional variables, years as a Rabbi, years as a chaplain, hours per week working with trauma victims, and hours per week performing pastoral counselling had significant effects on fatigue. Years as a Rabbi and time spent with trauma victims were both associated with greater fatigue, whereas years as a chaplain and hours of pastoral counselling were associated with less fatigue.

Although informative, Taylor and colleagues' study is limited in its application to other settings. As the authors mention, they did not consider what personal and/or community resources were available to these Rabbis, how effective these resources were, and why they were helpful. They conclude that future research should assist in answering these important questions.

In a similar study, Flannelly et al. (2005b) distributed questionnaires among a number of American chaplains and clergy who were called upon and participated in the aftermath of the terrorist attacks on September 11th. In order to understand the psychological effects stemming from working with traumatized victims, Flannelly and colleagues differentiated between burnout and compassion fatigue. In their study, compassion fatigue was directly related to the number of hours per week that participants worked with trauma victims. The number of days that responders spent at Ground Zero also made a significant contribution to compassion fatigue. Among those respondents who did not work for disaster-relief agencies but responded to the September 11th attacks, being a chaplain was associated with compassion fatigue in a positive way. In

other words, working with disaster-relief agencies, especially American Red Cross, reduced compassion fatigue. Being a chaplain and working in a hospital was associated with higher levels of burnout among those chaplains who did not work for disaster-relief agencies, but these effects were not evident among those chaplains who worked for disaster-relief agencies.

Also, being a chaplain and having CPE were associated with higher levels of compassion satisfaction. In general, the findings of this study indicated that compassion fatigue and burnout were relatively low as a whole. One reason, according to Flannelly and colleagues, is the debriefing practices used by American Red Cross, which may help reduce the emotionally adverse effects of disaster relief work among its volunteers.

The findings of this study also confirmed that compassion fatigue is directly related to the number of hours chaplains work with trauma victims and their families. While chaplains had significantly higher levels of compassion fatigue and burnout, they also had significantly higher levels of compassion satisfaction, demonstrating that this kind of work is both emotionally draining and rewarding. In conclusion, Flannelly et al. assume that working with patients in hospital settings also has similar advantages and disadvantages. Nevertheless, by stating that findings in this regard are far from being clear-cut, they made suggestions for future research.

In another study by Crossley (2002), professional satisfaction among a sample of 1533 U.S. chaplains was measured. The researcher sent questionnaires to all chaplains who were board certified by the Association of Professional Chaplains. According to Crossley, the vast majority of participants in the study were satisfied with their roles as chaplains. Four of five indicated they would definitely choose to be a chaplain again, if

given the choice; a similar proportion indicated they were glad most days they were a chaplain. About the same proportion of participants indicated they would choose to attend seminary again. While more than 90% of the chaplains said they had adequate or better than adequate support from their institution's administration, only half of them said they had adequate resources necessary for ministry. Most chaplains believed that other healthcare workers viewed their services in a favourable manner. Also, four-fifths of the chaplains believed they provided quality care. Nearly all chaplains responded positively to a question asking if they believed they were doing God's work. Among these chaplains, a sense that God values their work and their daily schedule was most important in determining professional satisfaction. Other factors that were significant in this study include, in order of importance, valued by the medical center, U.S. born, limited periods of poor mental health, being married, being female and tolerating significant institutional change. In Crossley's study, gender, marital status and place of birth were determinates of professional satisfaction.

Crossley draws two major conclusions from his study: first, most of the chaplains studied appeared to have a gendered level of professional satisfaction that is comparable to others in similar positions of responsibility in healthcare organizations. When it comes to healthcare professionals, argues Crossley, clergy are usually the most satisfied group. Religious belief, participation in organized religion and a positive outlook on life are all connected to increased levels of professional satisfaction.

The second important conclusion stems from the fact that most chaplains view change as a favourable element in the workplace. According to Crossley, chaplains are aware that healthcare is changing dramatically, but do not find change particularly

disarming. They apparently have little concern about job security. The vast majority of them reported adequate or better than adequate tolerance for change. The reason for this, according to Crossely, is that religious belief reduces anxiety over workplace change.

Working as a hospital chaplain is not an easy task. It is not possible for every priest, rabbi, or Imam to become a chaplain. In order to work as such, a chaplain should obtain a board certification which includes the certification of a faith tradition, a graduate-level theological degree, and four courses of CPE (Cadge, 2009).

To be a hospital chaplain requires not only professional credentials but also successful emotion management. Available research on the role and function of hospital chaplains indicates that their main contribution is not to perform religious rituals, but to provide emotional support. Chaplains must constantly hear people's stories of hardships and difficulties, and try to calm them down. Not only should they be emotionally strong, but they also need to convey an image as such. It is likely that the chaplains' own emotional and mental health becomes jeopardised as a result of constant emotion management under these expectations. Like other healthcare professionals, chaplains are required to perform both interpersonal and self emotion management. As such, they are subject to the multiple consequences of emotion management, such as emotional deviance, if they fail to perform emotion management successfully; or, emotional dissonance, if they receive contradictory or opposing feeling rules as to how they should manage their emotions. They are also subject to stress, distress, burnout and compassion fatigue. As the literature review in this chapter indicates, previous research on emotion management is not advanced enough to include all categories of medical professionals, including chaplains. Available research on chaplaincy is quantitative, measuring

standardized variables such as compassion fatigue and burnout by distributing questionnaires across large populations. During my initial investigations in Toronto, the hospital chaplains with whom I spoke described their job as emotionally challenging. In my opinion, the emotion management that chaplains go through in order to perform their job is rather unexplored. I would like to end this chapter by quoting reflections of a professional chaplain to indicate how heavily this job is invested with emotions:

For 10 years now I have served as a chaplain. During that time I have worked in a variety of clinical settings with people of many different faiths or no faith. Many I have seen only once or twice, yet I have known the experience of sudden intimacy in the face of crisis and life's unanswered questions. During these years, I have listened to many private thoughts, puzzled over the uncertainties of life with those facing terminal illness, walked with both family members and patients as they struggled with difficult decisions, pondered with some about the meaning of life and death, searched with others to find new meaning in what was happening to them, and listened to the voices of suffering in all their forms. I have said prayers at the moment of death, prayers before surgery and at the time of difficult diagnosis. At times I have been confessor, and at other times, confidant listening to the very personal experiences of illness, the impact it has had and the many feelings it has evoked.... I have witnessed firsthand how the ultimate questions and meanings in life become more clearly focused in times of crisis, how crisis became opportunity for needed change and how deepened appreciation emerged unexpectedly from the encounter.... My closest colleagues have been the medical and nursing staff. I truly feel a team spirit with them. They are not only my colleagues but my friends. I have shared with them my sense of helplessness when I could not "do" anything for the patient, like give medication to relieve suffering. I can only "be" there and attempt in some small way to bring to the bedside some measure of comfort through a caring presence (Vieira, 1990: 105-106).

Chapter Three

Methodology

Introduction

This study is based on a primary data source of 21 in-depth interviews with professional chaplains working, full-time and part-time, in different Toronto Hospitals. In this chapter I discuss in detail the methodological issues as well as the challenges and problems I encountered during data collection. Generally speaking, qualitative inquiry into sensitive topics or sensitive institutions such as healthcare institutions is challenging. Also, given the personal nature of in-depth interviewing, a heightened awareness of ethical issues should be maintained. As I will demonstrate, each methodological decision was cautiously considered, based on a combination of available resources, the obstacles encountered, consultation with my supervisory committee and after weighing the alternatives.

In order to reveal the backstage of the research process, I offer a candid account of the data collection and fieldwork process. Over the course of this study, I faced obstacles to access, the difficult task of recruitment, long hours of transcription, and laborious line-by-line analysis of over 400 pages of interview transcripts. But nothing was more frustrating than dealing with Research Ethics Committees and their administrative personnel who by jumping to conclusions or by their lack of knowledge about how ethics procedures should be followed put obstacles in the way of my research goals. I had to change my research plan from a qualitative study based on in-depth interviewing and ethnography to a qualitative study based only on in-depth interviewing. Criticisms of the ethics industry will appear in this chapter. I will also discuss issues such

as the qualitative approach, in-depth interviewing, response rate, protecting confidentiality, the changing shape of the interview guide, sample size, the timing and setting of interviews, and the procedures for data management and analysis. The criteria for assessing the credibility and validity of the findings will be presented in the concluding chapter.

Qualitative Approach

The very nature of my topic suggests a qualitative approach, specifically in-depth interviewing and participant observation. To fully understand emotion management in hospital chaplaincy, not only was it necessary to talk directly with chaplains who could provide firsthand accounts of their work-related emotional experiences, but it was also desirable to observe them in their natural work environment while interacting with patients and family members.

Qualitative research has three important features. First, it can be useful for exploration in areas about which little is known (Glasser and Strauss 1967; Strauss and Corbin 1990; Weiss 1994). Second, qualitative research is suitable to study interactions, complex meanings and the investigating process (Maxwell 1996). Third, it can provide novel and fresh understanding, in detail, of phenomena that are difficult to examine with quantitative methods (Strauss and Corbin 1990:19). Chaplains' emotion management has not been previously examined with the qualitative framework used in this study. As discussed in the previous chapter, most studies related to the well-being and mental health of medical professionals are either quantitative or from other countries than Canada.

Changes to Initial Plans as a Result of Minimum Level of Access

Before beginning this study, I did a comprehensive literature review that enabled me to identify the three approaches of symbolic interactionism, phenomenology and ethnomethodology as building blocks of a theoretical framework to study chaplains. I had a clear sense of the topics I wanted to examine prior to the beginning of the fieldwork. I had already consulted some of the relevant journals (e.g. *The Journal of Pastoral Care*) for statements that described various aspects of hospital chaplaincy. As part of my initial investigation to see if such a study was feasible, I also talked with a few chaplains and heads of chaplaincy departments in Toronto about the emotional aspects of their job. By combining these two sources of data, I began to construct the conceptual framework of this study as qualitative research to be undertaken in Toronto, a multicultural city with many hospitals and healthcare institutions. I chose Toronto as my research site because I realized most hospitals in Toronto have a spiritual care department in which a small number of full-time and part-time chaplains work to provide pastoral care and spiritual support for a diverse range of people. By estimation, 40 to 50 professional chaplains work across Toronto hospitals.

In my PhD proposal, I specified in-depth interviewing and participant observation as my two main research methods, arguing that in order to understand the emotional nuances of chaplaincy work, not only should I talk with chaplains about their work-related emotions, but I should also see how they interact with people in real work situations. I wanted to enrich my understanding by not only talking with chaplains in different Toronto Hospitals, but also by observing a few of them in two specific hospitals.

My fieldwork started in December 2009. Because my plan was to do a six-month period of fieldwork from December 2009 to May 2010, three months prior to the beginning of the fieldwork I was in Toronto trying to contact relevant authorities at two important Toronto Hospitals to inquire about the possibility of doing qualitative research in their hospitals. My intention was to conduct an ethnographic study in two different hospitals in order to analyse any differences and similarities of chaplaincy work in different contexts. The walking-time distance between the two hospitals is less than five minutes. Hospital X is a major hospital in downtown Toronto with a well-established spiritual care department in which chaplaincy services are concentrated on spirituality, rather than religiosity. Consequently, their chaplains are called spiritual care providers and are available to different kinds of clients irrespective of faith or religious tradition. This is in contrast to chaplaincy department at Hospital Y, where chaplains are specified according to their faith and can readily provide faith-specific care. Moreover, the two hospitals are basically different in terms of their clients. Hospital X is a regular hospital for adults, whereas Hospital Y is a paediatric hospital treating only children. This could potentially provide me with a comparative base to compare two different modes of interaction: adult vs. adult and adult vs. children. I was particularly interested to know how emotional dynamics involved in these two modes of interaction may be different or similar.

In both hospitals, the heads of chaplaincy departments welcomed me and seemed interested in my PhD topic. I was guaranteed that by following regular bureaucratic procedures, I would be granted permission to join their staff chaplains in visits with patients so that I could see how chaplains provide spiritual support for people in actual

work situations. However, as I will explain, obtaining such permission in the form of ethics approval is not easy in Canadian healthcare institutions. In my case, it appeared to be impossible.

As I mentioned earlier, three months before the beginning of fieldwork I began to contact relevant authorities to see what the necessary steps were in order to conduct research. Being mindful of the difficulties associated with obtaining ethics approval for such qualitative studies as ethnography, I expressed my desire to start the necessary paperwork and the application process well in advance of the fieldwork starting date. However, my request in one of the hospitals (Hospital Y) was not taken seriously until the very last moment, when I provided two letters from Memorial University in early December: a letter of support from my supervisory committee and a letter of ethics clearance from Memorial's Interdisciplinary Committee on Ethics in Human Research (ICEHR), declaring ethical approval of my research proposal.

Given the vulnerable nature of their target population, ethics gatekeepers at Hospital Y are extremely cautious in reviewing proposed research proposals as meticulously as possible before granting permission to any researcher who wishes to enter their institution. Just before the beginning of my fieldwork, I was told that in order to conduct qualitative research in that hospital, a research team should be constituted for the project with members from my supervisory committee at Memorial University, from Hospital Y itself and from the other hospital (X) involved in the research. Moreover, I was also required to prepare a new proposal (research protocol) that was different from my PhD proposal, explaining every aspect of the research in great detail. After consulting about the details of the requirements of Hospital Y with my supervisory committee at

Memorial, I was advised to exclude this particular hospital from my sample and look instead for data in places where ethics approval procedures are less onerous and time-consuming. During personal conversations with one of the members of the Ethics Research Board (ERB) at Hospital Y, I was told that in the most optimistic state of affairs, it takes at least four months for the procedure to be completed and ethics approval to be granted for research. After considering my timetable and available resources, I decided to exclude Hospital Y and look to the other hospital (X) for a small ethnographic study. However, things turned out to be even more complicated in Hospital X. I applied for ethics approval and my application was considered for expedited review. After the initial review, I was asked to do some rather minor revisions, but I was not informed if the study was granted ethics clearance.

Initially, everything at Hospital X started with amazing speed and level of comfort. I was surprised to see how easily I could gain access to the spiritual care department and its staff chaplains. With the help and cooperativeness of the department head, I officially started my fieldwork on December 1st after being told there was no need to fill out an ethics application. "All you need to do," wrote the secretary of the department in an e-mail on behalf of the head, "is to sign a confidentiality form and bring your University documents (the letters)." On my very first day of "fieldwork," I made tremendous progress: a photo ID badge was issued for me, introducing me as a student/observer/ researcher affiliated with the spiritual care department, which gave me access to different units of the hospital including the emergency department. I was given an e-mail account, computer access to the Hospital intranet and a key to the general office of the spiritual care department so that I could use office space and facilities by myself. On

this very first day, I was also given an orientation session to some units of the hospital. In an interesting coincidence, a chaplain trainee from Alberta who had completed some of her CPE units in Edmonton and wanted to take the rest in Toronto, started her three-month residency program at Hospital X on exactly the same day I was supposed to start my ethnographic research there. We met through the secretary of the spiritual care department, who introduced us in one of the units of the hospital where we were both given an orientation tour. When we met, the trainee found it interesting that a sociology student from Iran had come to Canada to study hospital chaplains. I, by contrast, was interested to know why she had chosen this line of work and asked about her feelings toward professional chaplaincy (e.g. does she want to develop a career in it?). As it turned out, she was not quite sure if chaplaincy was a suitable job for her. My first and brief encounter with this chaplain trainee was insightful, as her very first sentence made me think seriously: "there is a heaviness," she said quietly, "in this work that I'm not sure if I can handle." Because she was already receiving training in CPE, she decided to complete her experimental units and then consider staying or changing her career. It was my first encounter with a chaplain who thought this work may be too difficult. Unfortunately, my fieldwork was prematurely interrupted and I could not see her again to ask how she felt after completing all the units.

Members of the spiritual care department at Hospital X have bi-weekly meetings in which they get together and discuss their departmental agendas. I was invited to one of these meetings to briefly introduce myself and talk a little bit about my research. Personally, I found this an excellent opportunity to meet all the staff chaplains and approach a few for participant observation. As I talked about my research and the area of

study, they seemed very interested and expressed their willingness to cooperate. However, it was during this meeting that one of the members raised a concern with the Hospital's REB. In order to conduct any research involving patients, I was told, I should have first applied for ethics approval from the hospital, something which the manager of the department was oblivious to when I contacted him three months before fieldwork began. Although he was very cooperative and provided me with support, the manager's inattention to ethics-related issues put me on the wrong track and prevented me from processing my application in a proper time framework to obtain ethics clearance from the hospital. Needless to say, all facilitating measures (ID badge, email account, etc.) were useless until I applied and received ethics clearance. I did apply and after a time-consuming and complicated process, I was not informed of whether the project was given approval. This is because as an external person I was disqualified from directly conducting research in the hospital. In other words, an identified member of the hospital was required to sign the application form as Principal Researcher and I could only be the Co-investigator. Consequently, the REB only recognized the principal researcher as responsible for the research and was only in contact with that person. Although I was the one who filled out the application and satisfied REB's concerns after review, I was never contacted directly. Also, neither the head of chaplaincy department, who kindly accepted to sign as Principal Researcher, or its secretary ever informed me of any approval for the project. I was waiting for news, under the assumption that should anything happen, I would be the first person to be informed. By the end of fieldwork when no news came, and I complained about the way researchers are treated by the REB, I was only given an apology and information about the workload (huge number of applications) that the

hospital REB has to review. In other words, only after my fieldwork was complete and I needed to know why I was denied ethics approval, did I realize that the problem was not with me, but with the inefficient communicative or processing systems in REBs. "Almost all REBs in Canada," said the ethicist at one of these hospitals, "are under-resourced and trying to address the volume of work as efficiently as possible."

In-depth Interviewing

1. Sampling Methods and Sample Size

At the same time that I was trying to obtain permission for ethnographic work, I also began visiting different Toronto hospitals to recruit chaplains for my interviews. I only interviewed those chaplains who were willing to participate in the study. My method of sampling was *purposeful*: a non-random method of sampling in which the researcher selects "information-rich" cases for in-depth interview. Information-rich cases are those from which one can learn a great deal about issues of central importance to the goals of the research (Patton, 2001). With groups that are difficult to access, non-random sampling is appropriate. I used purposeful sampling because I knew exactly which category of professionals is relevant to my research. This is different from most random methods in which potential respondents have equal chances to be selected in the sample. Because each hospital had a limited number of chaplains, I needed to reach out to all potential respondents in a direct and straightforward manner, asking for their voluntary participation. All hospital chaplains who have work experience could be potentially "information-rich" cases. On two occasions, I also used a version of purposeful sampling known as the *snowball* or *chain-referral*: a method identifying information-rich cases

through referrals made among people who know of others who possess some characteristics that are of research interest (Birnacki and Waldorf, 1981: 141; in Lofland and Lofland, 1995: 38).

Like so many other aspects of qualitative research design, sample size was not strictly predetermined. As Lincoln and Guba (1985: 202) explain, if the purpose is to maximize information, then sampling should continue until no new information is forthcoming from newly sampled units; redundancy is the primary criterion. According to Douglas (1985: 50-4) researchers usually stop receiving new information somewhere around 25 in-depth cases. In qualitative in-depth interviewing, the number of interviews is usually small because the researcher legitimately sacrifices breadth for depth (Lofland and Lofland 1984:89). Weiss (1994) argues that because each respondent to a qualitative interview is expected to provide a great deal of information, the qualitative interview study is likely to rely on a sample much smaller than the samples interviewed by a reasonably ambitious quantitative survey study.

Though it was not possible to specify in advance the point of theoretical saturation, that is, when one begins to hear the same things from the interviewees, I did indicate in my dissertation proposal that 25 interviews seemed reasonable. Open-ended interview studies conducted by previous researchers start more or less from this number and go up to 50. I decided that 25 interviews might be sufficient because I realized, during initial investigations, that the total number of professional chaplains working in Toronto hospitals is between 40 and 50. Therefore, 25 interviews would cover half or more than half of the whole research population.

2. Problems Encountered

In each hospital I was treated differently. On four occasions my request to interview chaplains was turned down on the grounds that chaplains have no time or interest to participate in the research. Also, on four other occasions, I encountered obstacles from REBs and could not interview any chaplain. At other places, however, I was accepted warmly and chaplains participated in the study wholeheartedly. Overall, dealing with REBs was confusing. There is no standardized criterion whatsoever with regard to ethics clearance in Toronto hospitals, for in some places it is mandatory to apply for ethics approval before approaching chaplains, no matter how much information you want to obtain from the institution, how relevant your research is to the institution, what the subject of your research is, or if you already have ethics approval from another institution (e.g. your own university). In other places, however, things are less difficult and there is no need to apply for ethics approval. Similarly, there seems to be no commonly shared knowledge whatsoever among chaplains as to how they should participate in research from an ethics point of view. In my judgment, this is because of two reasons: (1) in most hospitals no one has ever approached chaplains before for research purposes, and (2) Toronto hospitals do a very poor job of educating their employees about ethics regulations. As I will explain, in each and every hospital I was treated differently. I had the experience of going to a hospital and interviewing a chaplain on the spot without prior arrangement, while on the same day in another hospital, I was rejected upon the very first encounter.

For better or worse, my first chosen hospital was a place in which I was treated so kindly that I assumed chaplains have a fair degree of freedom to participate in research.

This assumption was also reinforced after I was told, in Hospital X, that nothing needed to be done to interview chaplains, except to gain their consent personally.

On the first day of fieldwork for interviews, I found myself on a hospital floor with a few empty offices whose occupants' names and religious affiliations were written on the door signs. As I was wandering around trying to find contact information, a Catholic chaplain thought I was family member of a patient who wanted to talk with someone from the spiritual care department. She asked if I had anybody here hospitalized; I said no and explained that I am a PhD student of sociology at Memorial University of Newfoundland, currently in Toronto to do research about hospital chaplaincy. In less than five minutes, I was in her office while she was trying to reach her other two colleagues in the hospital, giving me email addresses or telephone numbers of chaplains she knew of at other hospitals, and checking her schedule for a free slot. We talked about a diverse range of issues; she put me in her e-mail list, talked about a book on Islam that she wanted to lend me, and set the interview time for two days later. Meanwhile, one of her colleagues, an Anglican Chaplain, appeared and we arranged a second interview time for 24 hours later. My third arrangement in that hospital was finalized in the elevator the next day when I was going to meet the Anglican Chaplain. Therefore, in my first hospital I conducted three interviews in three days. When I was done with that hospital, I already had a few contact addresses, and a useful base of information about large chaplaincy departments in Toronto.

This is how I started interviewing chaplains in Toronto, though later encounters were not quite so easy. In fact, apart from three hospitals, in most places I was told to meet the manager of the department before trying to contact any staff chaplain.

Therefore, instead of going to the chaplains directly, I soon learned to ask for the manager or head of the chaplaincy department. I had brief encounters with these managers in which I explained a little bit about my research, my key areas of investigation and gave them a copy of my consent form, emphasizing that I also had a letter of support and a letter of ethics approval from my university. Asking for maximum voluntary participation, I was under the assumption that it was the responsibility of the managers to let me know if something else needed to be done (e.g. check with ethics authorities) other than presenting my documents, explaining the research and asking for voluntary participation. Thus, instead of asking “do I have to apply for ethics approval?” I would say “I have been visiting different hospitals in Toronto trying to see if chaplains are interested in participating in my study. Please let me know if I can interview your chaplains?” In most cases, managers did not raise any concerns with ethics clearance. They gave my consent form, which had information about the study and myself as the researcher, to their chaplains so that interested chaplains could contact me directly. Most of my interview arrangements were made by e-mail. In two hospitals, managers said their clinical directors should be informed first. Once go-ahead responses were ready we would be able to arrange interview times. Nevertheless, in four hospitals, managers referred me to their REBs, saying that it was mandatory to apply for ethics clearance. In hospitals where it was mandatory, I never approached a chaplain without permission. I tried to respect regulations and follow procedures.

In a period of two and a half months, I interviewed 21 chaplains in Toronto. Although I visited 19 hospitals that had chaplaincy departments, I was able to recruit

chaplains from only 11 institutions. In other words, eight hospitals with chaplaincy departments were not included in the study for various reasons.

In two hospitals, chaplains were apparently extremely busy and had no time to participate in the research, while in two other hospitals I was told chaplains were not interested in being interviewed. As a matter of fact, in one of these hospitals I was treated rather unprofessionally. I went to the hospital twice and each time the secretary of the spiritual care department asked me to wait outside of the office in the hospital's main lobby so that she could page the manager. In my first encounter with the manager, he described himself as an "emotionally retarded chaplain" and laughed. He also made a joke about Newfoundland that I am not quite sure I understood.

3. Ethics Fiasco

In four hospitals, I had serious problems with ethics committees, which eventually led to termination of data collection prematurely. In another downtown hospital, Hospital W, I applied for ethics approval because, from the very beginning, I was told the only way to approach their chaplains is through the REB. I particularly wanted to recruit chaplains from that hospital because I realized that they have only male chaplains, a difficult-to-find phenomenon, which I needed to include in my sample. Most of my respondents were women and I needed to balance my sample in terms of gender. I was referred to an ethicist who gave me instructions on how to apply for ethics clearance. Following her advice, I filled out a long application form,¹ more than 70% of which was actually irrelevant to my study, and submitted it to the hospital's REB with other necessary documents. A few weeks later I enquired about the status of the application and

¹ Usually such applications are designed for clinical/medical studies. They ask, in detail, about different aspects and consequences of experimental research (e.g. use of drugs, etc.) and are not exactly relevant to sociological studies like mine. I filled out at least three such applications that ended up being useless.

was told that it was being processed, which usually takes “a few weeks.” I was thanked for my patience.

I had no choice but to wait. Meanwhile, my data collection was reaching its final stages and I was beginning to receive little new information from later interviews. As a result, I decided that I needed only a few more cases to complete my interviews. Since my intention was to diversify the sample by recruiting chaplains from as many different hospitals as possible, I visited yet another small hospital, Hospital Z, in which only two chaplains were working. The manager of the chaplaincy department at Hospital Z was regularly visiting patients while also performing managerial tasks. After talking about my research and the progress I was able to make up to that point, the manager named the hospital where she worked before coming to Hospital Z. Because I had already interviewed chaplains from that hospital, I knew several of her ex-colleagues who participated in the study and contributed to the data in significant ways. However, when I mentioned that I had already done interviews at that hospital, an unfortunate complication arose that turned out to be to my disadvantage. The chaplain and a secretariat of the hospital’s REB jumped to the conclusion that I was going to different hospitals and interviewing chaplains informally, without proper authorization. A few days after my visit to Hospital Z, an email was sent to all REBs across Canada with the following content:

Hi everyone,

My name is David and I act as the Secretariat for the REB at Hospital Z in Toronto.

The reason I am distributing this notice is because we have caught wind of a student by the name of Masoud Kianpour that may be collecting data (in the form of taped interviews) from your institutions without proper ethics approval. The study is entitled: “Emotion Management in Hospital Chaplaincy.” The student is from Memorial University in Newfoundland and

apparently has received ethics approval from the university's REB. He seems to be under the impression that this approval extends to anywhere he would like to visit. We know for a fact that he has contacted chaplains here at Hospital Z, but he has not received permission or ethics approval to do so. Although the study does seem to be low risk, the issue here is that he's receiving referrals for other chaplains' contact information from chaplains that he has interviewed. There are many red flags that are popping up from this study, most importantly being from the consent form that he is distributing. Please make aware of this student and his associated study as he may be coming in and out of your institution as he pleases without proper authorization to do so.

For more information, please don't hesitate to contact me.

Thank you,

David McLaughlin
JREB Secretariat
Education and Research
Hospital Z

I was informed of the notice by a sociologist from British Columbia who thought I deserved to know what was being said about me. Perhaps the only advantage that applying for ethics approval brought to me was an email from Hospital W sent in response to the above notice:

Mr. Kianpour has been in touch with us. He has ethics approval from MUN. He has been told by some institutions that the MUN REB approval is adequate and he can interview chaplains. Other institutions have told him that the institution's REB review and approval is required before he interviews their chaplains and he is complying with that. I hope this helps to clarify confusion.

After learning about what had been said behind my back, I contacted the person responsible for it and criticized him for sending out a warning notice before making a proper investigation. Although he immediately responded with his "sincere apologies," his email nonetheless was stigmatizing enough to prevent me from recruiting any more chaplains. It seemed no chaplain was willing to participate in the research afterwards. I was actually in contact with two chaplains to arrange times for interviews and despite

their initial positive responses, when the above email was distributed, they suddenly disengaged themselves and ignored my follow-up emails. One of them actually cancelled two arranged times and when I contacted him for a third meeting, never responded to my email. At the same time, another already-interviewed chaplain who wanted to check his transcript and inform me if there was a type-related or spelling mistake, used the same strategy and never responded.

On the same day that I went to Hospital Z, I also visited a large hospital in another area of Toronto where the manager of the spiritual care department welcomed me and, with his two staff chaplains, listened to my explanations. They were apparently happy to see a PhD. student doing research about their profession. We talked about different issues, from the current situation of a theocratic regime in Iran to the number of pages that my dissertation should have. Their suggestion was that I write a “not-so-voluminous” dissertation so that they would be able to easily read the findings. Not during the meeting, nor in the first two follow-up emails, did the manager mention any concern with ethics approval as a requirement for interviewing chaplains. However, when my case was publicized, he was so generous as to offer lessons on how research should be conducted:

Masoud: There has been a great flurry of e-mails among some of the chaplains with concerns about having your research vetted by the Research Ethics Board of each institution in which you are doing the research. This practice is normal procedure in hospitals. For example, a doctor or social scientist from University of Toronto may have authorization from the university Research Ethics Board but must get authorization from the institutions Research Ethics Board in which they do the research. We are used to that procedure. We realize you have research authorization from Memorial University but that does not allow you to do research in, for example, our hospital. You probably were not included in these communications. But I think it is important for your learning to be alerted to these concerns and probably it will be a good learning experience for you to present your research to the institutions' REB. I am surprised that your professors at Memorial

University did not alert you to these issues. I would be prepared to put you in touch with the chair of our REB so that you could get your research on the roster for consideration at our hospital. This will slow your research down some what but will be a good learning curve for you.

By the time I received the above email, I had already interviewed 20 chaplains, only a few less than the number planned. Receiving such an email, in addition to the way I was treated by those chaplains who decided to ignore my emails, convinced me that it would not be easy to recruit a new case. On the other hand, I had already applied for ethics approval from two hospital REB's and was hopeful of receiving at least one of these so that my chances of being looked at with less suspicion and receiving more cooperation would improve. I thought obtaining ethics clearance from a healthcare institution in Toronto would put me in a better position to negotiate access at other institutions. Consequently, I decided to stop visiting new hospitals and wait for an ethics clearance to come. Also, not many unvisited hospitals remained. After the ethics fiasco, I interviewed only one more chaplain whose manager had forwarded my email to her a few weeks before I visited Hospital Z.

As I began to work on my dissertation, the disappointing realization came that my efforts to satisfy REBs and obtain clearance were in vain. I never received timely ethics clearance from a hospital REB in spite of following the procedures and submitting all documents.

In conducting qualitative fieldwork for this study, I learned many lessons. The interesting lesson I learned about the ethics industry in Canada is that if you do not apply for ethics approval, people think you are disrespectful, and that you want to avoid regulations and undermine authorities; if you do apply, you receive nothing due to some

mysterious problems! When three months passed after I was in contact with the REB at Hospital W, the place where I was told my application was “in process and it usually takes a few weeks,” I contacted them again, explaining that my fieldwork was over and that although I no longer needed ethics approval, I certainly needed to know why, in spite of my application and following all the regular procedures, I was denied ethics approval.

I received the following email in response:

Dear Mr. Kianpour:

We are sincerely sorry that there has been some confusion with regard to your study. It seems that somehow it slipped through the proverbial cracks owing to our aging tracking system. We assure you that it was not our intention to cause you any undue delay. We hope that your future interactions with the world of research ethics are far more positive.

Another lesson I learned is that healthcare institutors in Toronto (or maybe in Canada generally) are somewhat paranoid about issues of research liability and research misconduct; they have become, in a literal sense, liability obsessed. As Beck (1992) argues in *Risk Society*, concerns about the ethical quality of research are characteristic of a society where anxieties about the unintended consequences of science and technology are increasingly common.

In the case of the Canadian Research Ethics Boards, Haggerty (2004) argues that the new formal system for regulating the ethical conduct of scholarly research (Tri-Council Policy Statement) is experiencing a process that can be called “ethics creep.” According to Haggerty (2004: 394), such a situation means “a dual process whereby the regulatory structure of the ethics bureaucracy is expanding outward, colonizing new groups, practices, and institutions, while at the same time intensifying the regulation of practices deemed to fall within its official ambit.” As an experienced member of a University-based REB, Haggerty further demonstrates his argument by analyzing the

scope of research ethics protocols, the concept of “harm” employed by REBs, the use of informed consent provisions, and the presumption that research participants will remain anonymous.

I had to terminate my fieldwork before I reached 25 cases because of the obstacles that hospital REBs put in my way. Moreover, I could not understand, from a logical point of view, that some REBs asked for ethics approval, yet in hospitals where I applied, I was not granted any. I understand that, as Lincoln and Guba (1985) argue, ethics gatekeepers would want to be fully apprised of researchers’ intentions in order to determine the risks and costs associated with participation in the study. Moreover, as Lee (1993) puts it, sometimes situations are so politically heated that a researcher may be mistaken as an “enemy infiltrator.” However, my research was not of a high-risk or sensitive nature (e.g. I did not want access to the personal health information of patients) and, more importantly, I was not trying to ignore REBs. The problem was not with me giving consent forms to chaplains, but with those managers who were unfamiliar with ethics regulations and those administrative staff who thought I was doing unauthorized research. As Brewer (1993) points out, the personality of the researcher can be an important resource for overcoming gatekeeper suspicions. Wherever I went, I presented myself as a doctoral student affiliated with a reputable institution, engaging in ethically sound inquiry, and seeking worthwhile knowledge. I also tried to build trust by displaying courtesy and competence. I am certain that not one of the chaplains who participated in the interviews was regretful after the interview. In summation, I found my dealings with ethics gatekeepers to be the most anxiety-ridden and frustrating phase of this study.

I believe there is no substantial difference between the chaplains of hospitals where I was able to get access, and those chaplains to whom I could not talk. The main difference is the strict ethics regulations and difficult administrative obstacles to research in the hospitals of the second group. Chaplains working in Toronto hospitals receive more or less similar training to become professional spiritual care providers. This assumption is supported by the fact that almost all chaplaincy training programs in Canada need to be certified by the Canadian Association for Pastoral Practice and Education (CAPPE), which sets similar and universal standards for the education and training of chaplains. Below is the list of hospitals I visited to recruit respondents for interviews:

1. Toronto General Hospital: teaching hospital affiliated with the University of Toronto
2. Toronto Grace Hospital: belongs to Salvation Army
3. Toronto Western Hospital: teaching hospital affiliated with the University of Toronto
4. St. Michael's Hospital: teaching hospital affiliated with the University of Toronto
5. Toronto East General Hospital: teaching hospital affiliated with the University of Toronto
6. Mount Sinai Hospital: teaching hospital affiliated with the University of Toronto
7. North York General Hospital: teaching hospital affiliated with the University of Toronto
8. Sunnybrook Health Sciences Centre: teaching hospital affiliated with the University of Toronto
9. Women's College Hospital: teaching hospital affiliated with the University of Toronto
10. Baycrest Centre for Geriatric Care
11. Princess Margaret Hospital: teaching hospital affiliated with the University of Toronto/cancer centre
12. St. Joseph's Health Centre: teaching hospital affiliated with the University of Toronto
13. Scarborough General Hospital
14. Humber River Regional Hospital
15. Hospital for Sick Children: teaching hospital affiliated with the University of Toronto
16. Bridgepoint Health: formerly Riverdale Hospital
17. Toronto Rehab
18. Health Providence
19. CAMH: Center for Addiction and Mental health

4. Demographic Characteristics of the Sample

The sample for the present study consists of 21 chaplains who work as full-time and part-time spiritual/religious care providers in different Toronto hospitals. It can be described in terms of several variables:

4.1. Age

Chaplains who participated in this study were between the ages of 33 and 65. Because it is not usually the norm to ask women about their age, I was not always comfortable with this question and could not ask all the respondents. In cases where I felt comfortable, I did ask and whenever I thought it was inappropriate, I estimated. The average age of the chaplains who participated in the study is approximately 52.

4.2. Work Experience and Workload

The least experienced chaplain had two and half years of work experience, in contrast to a chaplain who started her career 26 years ago and was retired from her full-time position but was still working part-time. The average work experience in the sample is 9.6 years, with eight chaplains having work experience more than 10 years and 11 chaplains less than that.

Also, 11 chaplains worked part-time and 10 chaplains worked full-time. One important reason to work part-time is the nature of chaplaincy work, which can become heavy and difficult if one dedicates oneself to it on a full-time basis. There seems to be a difference in the health condition of those who work part-time and those who are full-time: the latter are more likely to jeopardize their health, suffering from symptoms of fatigue and burnout. This is especially noticeable in hospitals where critically ill patients are admitted (e.g. trauma centers). Understaffed chaplaincy departments with only a few

full-time chaplains also seem like hectic environments in which to work. My request to interview chaplains in one of these departments was turned down on the grounds that chaplains do not have time to participate in such interviews. Among part-time chaplains, several respondents were convinced that if they worked full-time, they were likely to exhaust their energy and jeopardize their health. Another reason for part-time work was responsibilities outside of work (e.g. having a child at home).

4.3. Institutional Title

The sample includes 16 staff chaplains and five chaplains who balance managerial responsibilities with visiting patients. One chaplain was co-manager of her department and four chaplains were in charge of their departments. Chaplaincy departments in which managers of the department are also involved in clinical work are usually small in size. Large chaplaincy departments are often run by a full-time manager whose time and energy is completely devoted to managerial tasks and not bedside work.

Naturally, to be both a chaplain and manager of the spiritual care department is more stressful than being only a chaplain. Managers are responsible for satisfying their clinical directors and other authorities in the hospital hierarchy, while also attending to the needs and sensibilities of their subordinate staff. This can put some managers in a conflict situation whereby they are pressured, on one side, to provide quality care with a limited budget and, on the other, to push their staff to work hard.

4.4. Sex

Eighteen of the 21 chaplains in this sample are women. I could not recruit more than three male chaplains for interviewing. Hospital chaplaincy is a job predominantly occupied by women. Most male chaplains in Toronto Hospitals are in managerial

positions (e.g. manager of the spiritual care department or chaplaincy training program) and as a result, rarely participate in bedside work. Unfortunately, one of the institutions in which only male chaplains worked did not allow me to approach their staff, even though I applied for ethics clearance.

It would have been helpful to recruit more male chaplains and see in which ways emotion management strategies and emotional expressions can be influenced by gender. Based on the three interviewees I conducted with male chaplains, I am not convinced that there are many significant differences between male and female chaplains when it comes to emotion management strategies. Chaplains in this study, irrespective of gender, are inclined to follow their CPE and draw, more or less, on similar sources to manage their emotions and protect their mental health. Women, for example, did not say that they tend to cry more often than men or get overwhelmed more often than their male colleagues. The only exceptions are (1) physical contact: in both genders respondents indicated it was preferable when the other person is of the same sex, (2) dealing with baby death: female chaplains can identify more with pregnant women who suffer from miscarriage or death of their baby after birth, and (3) emotional dissonance: sometimes gender-specific expectations are at work which define feeling rules for chaplains. After all, feeling rules are influenced by gender. As Hochschild discusses extensively, women and men are expected to experience and express emotions differently. In this study, I was not able to draw any gender-specific conclusions that show one category tends to cry more often than the other. Had I been able to recruit more male chaplains, I may have been able to explore the relationship between gender and emotion management in greater depth.

4.5. Ethnicity

In terms of ethnicity, the majority of the respondents are white, with European and Anglo-Saxon backgrounds. However, the sample also includes two Asian chaplains (with Chinese and Indian backgrounds) and one from the Caribbean Islands. I do not assume that non-white respondents encounter different sets of feeling rules or use different techniques for managing their emotions. Although non-white chaplains may encounter more emotionally challenging situations because of their ethnic backgrounds, evidence of different emotion management techniques based on ethnicity is limited in this study given the widespread tolerance among chaplains, the multicultural milieu in which they work, and the nature of their professional institutional context.

4.6. Marital Status

Ten chaplains were married with at least three being in their second marriage. A closer examination shows that of the remaining respondents, five were single because they never married and three were single because of divorce. Three chaplains also were not married but lived with a partner of the same sex or the opposite sex. Overall, 14 chaplains had children or were in a parental relationship by looking after step children.

4.7. Religious Affiliation

In terms of religious affiliation, the sample includes chaplains from five different religions and faith traditions. The majority of the chaplains (16) were Christian, including five chaplains belonging to the Anglican Church, three to the Roman Catholic Church, two to the United Church of Canada, and one to the Baptist Church. The remaining four Christian chaplains did not specify their Church. Several of the chaplains were church ministers. I also interviewed two chaplains from Buddhism and one from Islam, who is

actually the first Canadian Muslim chaplain. I could not interview more than one Jewish chaplain because in the hospitals where I wanted to conduct interviews, Jewish chaplains (Rabbis) did not have the time or interest in participating in the study. Finally, I interviewed a pagan chaplain,¹ who is a believer in the modern paganism movement and is apparently one of only two such chaplains in Canada (the other one being in Edmonton).

While chaplains can be categorized in terms of their religion, it is important to note that most of them are multi-faith chaplains, meaning they are available to provide spiritual/religious care for people of all religious backgrounds. In fact, some chaplains prefer to be identified as spiritual care providers and look at their faith as a personal matter.

4.8. Level of Education

All of the respondents, but one, had a master's degree. 10 chaplains had a Master of Divinity (MD), and four had a Master of Theological Studies (MTS). These two degrees are the most commonly found degrees among professional chaplains in North America. In most chaplaincy training programs it is mandatory to have a master-level degree in theology as a minimum requirement. Prospective students who do not have a theological education but still wish to enter the chaplaincy training program must meet some other equivalent standards, which often involve a master's degree in another field supplemented by few courses in theology. Of the two Buddhist chaplains in the sample, one had a Master of Arts in Buddhist Studies, and the other had an incomplete Master of

¹ In contrast to monotheism, followers of paganism, whose roots go back to the ancient Roman Empire, believe in a multitude of gods. The pagan chaplain I interviewed was working in a hospital where chaplaincy services revolve around spirituality and not religiosity. Consequently, this chaplain introduces himself to patients as a spiritual care provider, not a pagan chaplain.

Religious Studies with a concentration on Eastern Traditions. One of the chaplains had a Master of Education and Counselling, and another one had a Master of Ministry and Spirituality. Finally, the pagan chaplain had a degree in Celtic Studies. In addition to their Masters of Divinity, one of the chaplains had a Master of Arts in English and another one was a seven-year PhD student of Ministry at the University of Toronto.

All of the chaplains had gone through the CPE residency program, which is required by CAPPE. The program is composed of four units of experimental work in a hospital setting. During CPE, trainees are given specific tasks and responsibilities; they regularly visit patients, family members and do on-call work. Meanwhile, their performance is closely supervised to see how well they progress. In an intense period of experimental work, chaplain trainees come to realize if this is a suitable profession for them. Their understanding of their capabilities and suitability for this job is continually being examined through residency work. They may encounter real situations that surprise or shock them, but it is through these experiences that they actually feel what it means to be a chaplain and if they want to become one. As the most essential component of any chaplaincy training program, successful passing of the CPE program paves the way to becoming a professional chaplain certified by CAPPE. While the minimum requirement is four units, several chaplains in the sample had already passed an extra unit to become a specialist of one specific area. Only one chaplain did not have all four units completed in her resume.

4.9. Social Class

I did not directly ask the respondents about their social class background. I was, however, able to get several indirect indicators. Questions about sources on which

chaplains rely to protect their health and well-being enabled me to gain a better sense of the chaplains' position in the class structure. With a few exceptions, the respondents tended to come from middle class backgrounds.

5. Technical Matters in In-depth Interviewing

In semi-structured interviewing, a number of research questions are prepared in advance but such questions are not so inflexible as to predetermine all the subsequent questions of the interview. Instead, they should be designed in a way that allows subsequent questions to be improvised in a careful and theorized way (Wengraf, 2001: 5). In such an in-depth, qualitative interview, three kinds of questions can be distinguished: (1) main questions that begin and guide the conversation, (2) probes to clarify answers or request further examples, and (3) follow-up questions that pursue the implications of answers to the main questions (Johnson, 2002: 103). In-depth interviewing requires openness to new ideas not anticipated at the beginning of the research. The information obtained initially helps the researcher develop subsequent analyses. However, by designing a number of main questions in advance, the interviewer can avoid the issue of inconsistency and the problem of respondents dominating the conversation in ways that enable them to avoid key issues. Even though I went into the interviews with a pre-selected theoretical perspective that would frame the presentation of my findings, the logic and flexibility of qualitative interviewing always remained central in my work.

6. The Interview Guide

The interview guide in this study is semi-structured with open-ended questions. It has a loose chronological structure. The topics, most of which were generated by the literature review, are related to various emotional experiences that chaplains go through

as a result of working in a hospital. The chaplains I interviewed also played an important role in highlighting relevant details and opening up new lines of inquiry.

I gave considerable attention to the wording of the interview questions. For example, instead of “how do you react to a situation...” I would say “how do you deal with a situation...” In fact, Bowser and Seiber (1993) argue that if the research question is not sensitive to the communication style and language of respondents, not only may they misunderstand the question, but they may be offended by it and not give valid responses. I tried to avoid using sociological terminology that would be unfamiliar to the respondents. My first interview with an Anglican chaplain seems now like a comedy of errors: not only was I somewhat nervous during the interview, but I also left my notebook in her office afterwards. However, once I could memorize the guide, I was able to subtly navigate the subsequent interviews. As my skills as an interviewer improved, I was able to think faster, which enabled me to connect with themes implied earlier in the interview. I could ask, for example, how the respondent reconciles what appeared to be inconsistent statements.

The following questions constitute my first interview guide, but each conversation was flexible enough to allow for additional probes. The questions were predominantly related to chaplains’ work-related emotional experiences:

- How do you describe your job from an emotional perspective?
- What role do emotions play in your job?
- How do you rely on emotions to perform your work?
- How do you deal with situations in which you encounter critically traumatized or desperately hopeless patients?

- How do you help patients cope with emotional problems in the face of disease or other health-related issues?
- What sort of impact does your job have on your home life?
- How do you rely on emotions to establish spirituality in patients?
- What is the most emotionally challenging task in your job?

I modified my sampling plan and interview guide several times in response to unforeseen circumstances and emergent insights. Also, some initial research questions were excluded as a result of their inability to elicit useful information. For example, in my very first interview, I realized that a question like “what role do emotions play in your job?” is not likely to provide me with valuable, phenomenologically rich information. I realized that with such a question, instead of actual accounts of situations in which emotions were significant, what I would probably obtain is abstract statements of what chaplains think about emotions. Furthermore, I could not even be sure if our definitions of emotion were similar. Therefore, my interview guide was changed several times as one interview was unfolding after another. New questions and revised questions were developed in almost every interview. Here are a few examples of questions that were added to the interview guide:

- What are the resources on which you rely in order to protect your mental health and emotional well-being?
- When was the last time that you were so moved by a situation that you cried?
- How often do you use physical contact in interaction with patients or family members in order to create emotional intimacy?

At the end of each interview, I asked respondents if there was anything we did not talk about that they would like to add in order to enrich my understanding of their job from an emotional perspective. This question (which I used to call “enrich question”) turned out to be a good one, as in some cases it provided valuable and interesting information. For example, through this question a few chaplains talked about more specific and idiosyncratic practices they use to protect their mental health.

Ethical issues as well as practical matters related to the conduct of qualitative interviews are very important. Generally speaking, important matters must be carefully taken into consideration when conducting qualitative research. According to the Tri-Council Policy Statement, any research involving human subjects can begin only if issues of free and informed consent, confidentiality and voluntariness are completely observed (O’Neil, 2002; Hoonaard, 2002). Not only should participants be given these assurances from the beginning, but researchers should also do their best to observe them all throughout the research. To be informed, the participants must know what the research is about, what potential consequences it might have, and what risks might be involved.

When it comes to practical issues, what is of crucial importance is how the interviewer feels and acts during an in-depth interview. The manner and mood of the interviewer can greatly affect the quality of the result. Nervousness, for example, may worry the interviewee, leading him or her to prematurely terminate a conversation with quick responses and inadequate explanations. But if a researcher appears cool and relaxed, an informative and rich interview is possible. Rubin and Rubin (2005: 78) suggest that interviewers take the time to learn something about the interviewees and the research setting. To remain relaxed, the researcher should not conduct too many

interviews in a short time. Taking rests between two interviews and avoiding back-to-back work helps the interviewer remain relaxed. A psychological space, according to Rubin and Rubin (2005), should be created to separate one interview from another.

Another issue is personality. Aggressive interviewers may scare interviewees by demanding evidence rather than pursuing controversial issues in a less threatening manner. At the other extreme, if an interviewer is too passive, he or she may fail to follow upon sensitive questions, or ask for clarification of vague and general replies. A “balance of personality,” according to Rubin and Rubin (2005), should be maintained. Initial impressions are also important. By being too intense, an interviewer may intimidate the interviewee and by being too gregarious, the interviewer may lead the interviewee to lack seriousness. Another issue is the degree of empathy with which the interviewer approaches the interviewee. It is important to look empathic and show both emotional care and intellectual interest in what the interviewee says. However, by being too empathic, interviewers can create biased results: if they identify too closely with those under study, they may only ask questions that please the interviewee. It is thus important to maintain a balance in matters of empathy.

Given the importance of the above issues, I tried to pay specific attention to the quality of every single interview. I began each interview by introducing myself and explaining the purpose of the study. Respondents were given a copy of the informed consent form for their records and I asked all respondents to sign a copy of the form and return it to me for my records. They were assured that information obtained during the study would remain confidential.

To engage my subjects more willingly and wholeheartedly, I sometimes provided facilitating information, such as the personal value of the research. In my consent form, I reminded them that they can refuse to participate in the research and that nothing inappropriate will happen to them. I also emphasized that they had the right to refuse answering a question if they find it too personal, inappropriate or vague. Moreover, to avoid potential problems, I used an indirect questioning style that allowed respondents to determine how far and deep they wanted to go in discussing an issue. To assure anonymity and confidentiality, pseudonyms have been used in labelling tapes and transcriptions. Pseudonyms are also used throughout the text and when necessary, details in the narrative have been disguised. In fact, except in the section for acknowledgements, no person's real name is mentioned throughout the text.

7. Interview Settings

In terms of interview settings, the location should be private, comfortable and relatively free of noise. Interviewing in an environment free of noise was possible in this study. Except in one case, all interviews were conducted in hospitals where chaplains worked. Logically, the office would be the ideal setting to conduct in-depth intensive interviews with employees, given that it is the place where they would be most likely to focus on work and issues related to work. Most chaplains had small offices, which they sometimes had to share with another colleague. I conducted most of my interviews in the chaplains' offices when nobody else was around. To avoid discomfort, some respondents arranged for a bigger space (e.g. conference room), but the choice of the office, for the most part, was good as it provided a safe setting in which the respondents could close the door, have their calls held and speak with me for 45 minutes to an hour with few

interruptions. In a few cases, code blue (cardiac arrest) was signalled and we had to pause momentarily so that the chaplain could ensure that a colleague would take care of the situation. Chaplains' offices also provided me with an opportunity to see their workplace, and to experience the general atmosphere, including ornamental objects used to decorate the space. In the cases of Anglican and Catholic chaplains, offices were usually filled with small statues of Jesus and Mary. Almost all chaplains had short poetry, wisdom mottos and religious sayings attached to the walls or their office doors. Most of these sayings were about kindness, sympathy and compassion.

Data Management and Analysis

Qualitative fieldwork may be characterized as emergent and interactive. The researcher begins with goals and a general plan. Throughout the research process, however, this plan is changed to obtain information in a contextually appropriate manner (Lincoln and Guba 1985). The evolution of the research design is guided by a continuous and concurrent process of data collection and analysis (Glaser and Strauss 1967). As Loftland and Loftland (1984) argue, gathering, transcribing, coding and analyzing data are complex, overlapping and interweaving phases of the research process.

Strauss and Corbin (1990) advise researchers to transcribe only as much as is needed. Because I was not sure what would become relevant, I decided that full transcriptions were necessary. This produced 427 single-spaced pages. The average length of an interview transcript was 21 pages with a range from 18 to 26.

As a non-native speaker of English, I faced an additional challenge of making sure that words and sentences were as accurate as possible, I was lucky to interview a

group of people who are very soft-spoken. Most chaplains tended to speak slowly and with good articulation. On occasions when I was not sure about the meaning or pronunciation of a specific word, I consulted online dictionaries for different suggestions and chose the one which seemed most compatible with the context. Ultimately, where it was impossible to discern the exact words which respondent was saying, I paraphrased. However, speaking too fast was not a problem in most interviews, and except for only one interview (which took place in a coffee-shop), I was not disturbed by background noise.

The search for order in the data and developing a coherent classification system is time and labour intensive. As I critically examined the interview transcripts line by line, I was attentive towards what was being revealed. The insights that I developed from the preliminary analysis shaped subsequent stages of data collection. As Lincoln and Guba (1985: 209) explain, “every new act of investigation takes into account everything that has been learned so far until salient elements begin to emerge, insights grow, and the theory begins to be grounded in the data obtained.”

Essentially, this study had two central purposes: (1) to obtain empirical data that demonstrates the emotion management that takes place in hospital chaplaincy and (2) to identify resources or strategies that chaplains rely on in order to protect their health from any negative consequence of emotion management. As I coded my first interview, I already had codes that were derived from the literature. I was looking for evidence of different emotion management techniques. As my interviews progressed, initial theoretical insights came into sharper focus. The creation of additional codes happened frequently and at such random times that it is impossible to give a full account of them. I

tried to approach each transcript, as Miles and Huberman (1994: 100) say, “prepared to let the interview breathe and speak for itself.”

Lofland (1976: 9) argues that unlike more conventional interviewing, which is oriented towards attitudes, in-depth interviewing is oriented towards collecting instances of problems and how they were managed. One important goal of intensive interviewing, he states, is to construct records of action-in-process from a variety of people who have normally performed these actions time and time again. Weiss (1994) acknowledges that because the in-depth responses obtained by qualitative studies cannot be easily categorized, analysis must rely less on counting and correlating and more on interpretation, summary and integration. Therefore, more than anything else, the findings of this study are supported by quotations and case descriptions. To be more specific, my approach to presenting the findings is what Sandelowski (2000) calls “qualitative description,” with a phenomenological inclination: that is, my goal is to describe emotion management experiences as they are lived and felt by chaplains.

According to Sandelowski, the general view of descriptive research as a lower level form of inquiry has influenced some researchers conducting qualitative research to claim methods that they are not in fact using, rather than describe the method they are using, namely qualitative description. Qualitative descriptive studies have as their goal a comprehensive summary of events in the everyday terms of those events. Researchers conducting such studies stay close to their data and to the surface of words and events. Consequently, language is a vehicle of communication, not itself an interpretive structure that must be read. Yet such surface readings should not be considered superficial, or trivial and worthless. The word “surface” conveys the depth of penetration into, or the

degree of interpretive activity around, reported or observed events. As Sandelowski (2000: 336) puts it, “there is nothing trivial or easy about getting the facts, and the meanings participants give to those facts, right and then conveying them in a coherent and useful manner.”

Qualitative description is a method of analyzing data that researchers can claim unashamedly without resorting to methodological acrobatics. Such qualitative analysis is the least interpretive of the different qualitative analysis approaches (c.g. phenomenological, ethnographic, grounded theory, etc.), in that there is no mandate to represent the data in any other terms but their own.

Now that I have reviewed the methods utilized in conducting this study, the next three chapters discuss the data in detail. I first describe hospital chaplaincy focusing on emotional factors, then the typical situations in which chaplains are likely to be emotionally challenged, and finally I discuss the resources or strategies that chaplains draw on in order to manage their emotions and perform their job.

Chapter Four

Description of Hospital Chaplaincy

The previous chapter discussed recruitment sites, characteristics of the interviews, problems with REBs, sample size, and the changing nature of the interview guide. This chapter provides research findings and describes the emotional aspects of hospital chaplaincy. In other words, it discusses typical situations in which chaplains are likely to interact with emotionally overwhelmed patients. Sometimes I will rely on lengthy quotations to describe these situations. The next chapters discuss the emotional challenges and difficulties, techniques, strategies and resources that chaplains may employ in order to perform emotion management and protect their mental health.

Why Become a Chaplain?

Chaplains mentioned different reasons as to why they decided to choose spiritual care for a career. Four categories or reasons can be identified, which I will describe as follows:

1. Religious calling
2. Experience with hospitals and medicine
3. Seeking meaning and spirituality
4. Circumstances encountered

For many spiritual care providers, working as a chaplain is not simply a job or occupation, but a vocation that is shaped by their religious values. As a chaplain said: "I wanted to do something where I could respond to my faith and God and my interest in

people” (interview No. 2). In fact, several respondents believed they did not choose this field of work. It was rather chaplaincy that chose them:

I didn’t choose it. It chose me; I wasn’t planning to become a chaplain. My plan was to study theology, and....then I decided to do a Clinical Pastoral Unit and from that it just developed and then a job fell in my lap so I applied for it.... (Interview No. 4).

For one respondent, who was actually a church minister, chaplaincy turned out to be a good outlet for reconciling her liberal religious ideas with the “church’s strict rules,” enabling her to answer a religious calling while allowing her to practice the kind of ministry she liked:

There was this discomfort there for me about “am I going to be able to work with these folks [Church ministers]?” “Would that fit?” Plus I know I wanted to remain in the church; I knew that that was my calling and I kept hearing them saying “we don’t think you’d be any good pastorally.” So I went and I did a year of residency in clinical and pastoral education and liked it... (Interview No. 3).

Some of the respondents were already familiar with hospital environments, either because their previous job was related to healthcare or because they had experiences of hospitalization and sickness. Some chaplains were also religious and very much interested in medicine. Consequently, they thought hospital chaplaincy was an ideal place to unite their religiosity with a passion for medicine:

When I was a young person in high school I intended to go to medicine; the only thing I ever wanted to do... that is how I started university and then I began to have that experience of feeling called to do something for God that was not what I had intended to do; so that’s why at that time and point I switched my major from science and did my undergrad in psychology and then I did my divinity study... so I went to congregational work for a number of years and then the opportunity to take the CAPPE training came and I thought I would take one unit and see. Because there was always this love of medicine that I’ve always had....you know, there is always that partnership inside me, so I took that one unit and it was a marriage of the two things I loved most. It was a marriage of spiritual and religious world that I was

already committed to and a part of and that old love of science and medicine that had attracted me... (Interview No. 12).

Likewise:

I was a minister of a congregation for a number of years, ten years; and I was a lab tech, medical lab tech, years ago so hospital is like home to me, but I became – as a pastor of a congregation – I became more liberal in my thinking, in my theology, so that coupled with love of hospital which I had always, like as a pastor of a congregation I used to visit patients in hospital, so all those things.... (Interview No. 11).

Another chaplain mentioned her early socialization within a hospital and with care giving as a reason to choose chaplaincy work:

I worked in the hospital, when I went to university as a nurse aid. I took a degree in biology because at that point and time I was sort of thinking about medicine.... I have always been very comfortable in hospitals. My aunt was paralyzed for 16 years before she died and she died when I was six, so for ten years before I even was born she was paralyzed and she was a quadriplegic, so I was very comfortable with sick people being around because we lived next door....and my grandmother was a nurse aid so there was a lot of hospital in my background.... (Interview No. 7).

Only one chaplain was initially not sure about working in a hospital setting. She actually held quite negative attitudes towards hospitals as places where there is only pain and suffering, but her perception changed as soon as she entered a residency program and began to visit patients as a multi-faith chaplain.

In three cases, chaplains witnessed or experienced serious health problems that led to deaths of their loved ones or to their own hospitalization. Such experiences can be so profound and heart-touching that they may actually leave one with a sense of appreciation for the value of care giving, especially spiritual care. In a rather remarkable story, one chaplain describes how working in another profession, social work, coupled with a series of deaths and health problems among family members, convinced her to switch her career from social work to chaplaincy:

In that year my father died and I was with him when he died; and then my brother died in a complication related to AIDS and my mother was.... she was in a nursing home.... she was sick for about 13 years with heart and stroke and stuff, so in 1997, in November 97, my brother died in January 98 my mother died and then three months later I was diagnosed with colon cancer, so then I had a year of like two surgeries, six months of chemo treatment and then I had..... I continued to study but not like a heavy load and then I was diagnosed with cervical cancer, so then I had surgery, I had radiation five days a week, so this was part of my education (laughter).... so when I was well again then I started the training in chaplaincy and partly because I had like a fresh sense of what it is like to be in the hospital.... like the kind of care that you would see from different people and who are the people that really kind of nourish you.... like who are the scientists and who are the healers....and some people are scientists and healers in one sometimes....(Interview No. 20).

The distinction between scientist and healer in the above account can be compared to medical and spiritual approaches, which I will elaborate on later.

Another chaplain had a hospital experience through which she met different healthcare professionals and decided to become one. Interestingly, not only was she not pleased with the quality of the service that her chaplain was able to offer, but she described her as a “social butterfly” whose presence was “absolutely useless.” The following account indicates the importance of professional training in hospital chaplaincy:

I had an experience with a family member who was diagnosed with cancer; my husband was diagnosed with cancer, and he was a family physician and I didn't know anything about hospitals or his world until I became involved in that as a family member and I discovered that there are incredible people here who made such a big difference to us in our journey and giving us hope and giving us support, encouragement, and some who had the opposite effect, too, but....

Interviewer: like you got angry and frustrated?

Chaplain: Yeah, but, you know, as he was approaching his death, I was thinking what I am going to do because I had a Master's degree in theology but I hadn't worked as a pastor; I had done freelance work and chaplaincy work seemed to be able to pull together my personal and my professional experiences from a number of different areas and it was a good fit for me.

Interviewer: So you were so moved by the experience that you decided to become professionally involved?

Chaplain: Well, the truth being in almost 18 months the only chaplain we met was a volunteer chaplain who said that she wasn't allowed to pray with patients even though she was Christian and she knew we were – we were from the same basic faith tradition – and my memory of her is wearing a very festive Christmas vest on Christmas Eve Day telling us about her trip to Florida and she was absolutely useless....

Interviewer: in which sense...?

Chaplain: She was there as a social butterfly; she wasn't there as somebody who could be there with us in our pain, in our sorrow, and in our suffering... (Interview No. 15).

While, not surprisingly, a good number of the respondents came from a religious background grounded in some form of organized religion or another, at least four chaplains changed their career paths drastically from an academic field unrelated to chaplaincy in order to become involved in a kind of work that would nourish their life and give meaning to it. One chaplain practiced law before becoming a chaplain and thought dealing with the reality of life in court prepared her very well to practice chaplaincy in a hospital. In an interesting case, another chaplain said she was an atheist for a long time, but after a turning point caused by music, she became a believer in God and chose Christianity as her faith. At the same time:

I was in computer doing IT and that was not satisfying to me; I wanted to do more, to live within my [new] faith so I joined a community, a religious community. I was with sisters for two years and.... but that was not right for me. So I needed to find out what I wanted to do; I didn't want to go back to the computers, so I thought coming to the chaplaincy would be a good way of living my calling really.....(Interview No. 5).

In another two cases, chaplains wanted to do something more spiritual and meaningful:

I think I wanted to do something meaningful...I spent 16 years in banking. So I wanted to do something that was meaningful. I wanted to do something that was spiritual, that without being directive..... In this job we get to elicit the spirituality out of the patient or the family member who are.... at a time when it's really necessary.... (Interview No. 8).

And:

I used to work in the business world. I had my own company as a consultant and I did project management in my own company with the CIBC bank, but throughout my life I always felt that the work I was doing was somehow missing something. And a good friend of mine had a brain tumour and I was with him for the last six weeks of his life. He and his wife, and that experience gave me a sense of what it was like to have a very profound connection even though it was the most distressing period of their lives. [Of course] there wasn't [enough] time for all of the niceties that we wanted to get engaged in when we communicated.... there wasn't time for it. We got down to the essentials of what life is about and the things that weren't so important just naturally fell away; so it was something that really spoke to me... (Interview No. 14).

The youngest chaplain in the sample enrolled in a Master of Religious Studies program but left it incomplete because:

I was looking forward to an opportunity to learn more about the history of this tradition [Buddhism] and other traditions and engage with people around the teachings: how do we apply these to our lives? What does it mean to you? How do you understand this? And found that for many folks, teachers and students, their reason for being there wasn't necessarily, you know, heart-centered, that it was maybe more of an intellectual curiosity or pursuit. They were interested in teaching or the more academically focused study of religion rather than how do we apply this to life, what does this mean for my soul? So a friend of mine who was part of this Buddhist community back in Toronto discovered that chaplaincy was accessible or is becoming more accessible to people of different traditions, and found his way into CPE training and as I learned about his experience I became very interested, quite quickly found a CPE program in Montreal, applied and was accepted and everything just unfolded from there.... (Interview No. 19).

Finally, two chaplains thought they became chaplains quite accidentally or by pure chance:

When I was doing my Master's degree I found a brochure about chaplaincy that you can do it in 12-week units as a field education credit. So I did that and

then I discovered that I enjoyed it and I had some strength in it; so I decided to pursue more training.... (Interview No. 18).

The other chaplain received training in chaplaincy because he was laid off. He used to visit prisoners on a voluntary basis. However, inside the prison he realized that:

We had a lot of crises in the prison system at the time in Toronto; I was able to help, like break some of those problems, like break problems in a positive way and so at the time there were no Muslims training in spiritual and religious care, so I wasn't interested. I worked with a consulting engineering firm as a technician, drafting all of cad and that kind of stuff, but I got the opportunity to train as a result of being laid off from my job. I got the right time to do the training because it tended to be the full-time training at September, but I was laid off earlier in the year....(Interview No. 10).

As is obvious in this section, some chaplains believed special reasons were at work to make them choose this line of work. For some of them, it was the power of personal experience that touched them and brought them into this profession. Discussing these issues is important in that we can come to understand the attitude chaplains hold toward their job and the way they feel about it. I will later elaborate on this issue in detail.

Chaplain vs. Spiritual Care Provider

When the emphasis is on providing spiritual care in general, chaplains visit all patients irrespective of their religious affiliations, but if patients ask for a chaplain of their own faith, then faith-specific chaplains are called. Although the procedure is different from hospital to hospital, in places where the emphasis is on spirituality, chaplains prefer to be called *spiritual care provider* or *multi-faith chaplain* rather than chaplain. Also, their ID badges introduce them as spiritual care providers and they divide the work not according to different faith groups, but according to different hospital units. It seems to be extremely important for some multi-faith chaplains to be identified as

spiritual care providers. One of my respondents, in particular, was very keen on this issue. She kept on reminding me that her job is not about religion as much as it is about spirituality. I joked about a line in *Catch-22*, a comedy about a group of American soldiers in a U.S.A. military base. There is a chaplain in the movie that is consistently called "Father" by all his fellow soldiers who know his sensitivity to this issue and how to take advantage of it. Each time they call him Father he responds in anger: "I am not a father; I am a chaplain!" My story was not even finished when the chaplain replied: "I am not a chaplain; I am a spiritual care provider." Similar to the above respondent, another multi-faith chaplain said:

I would never go and say I am a chaplain. That's a loaded word. I might go and say I am with spiritual care and this is what we do. If they [patients] want me to leave I just say fine, I'll go; I might leave them with the pamphlet or I might just go (Interview No. 5).

In order to be accepted professionally, multi-faith chaplains identify themselves as members of the medical team who are employed by the hospital. By expressing *role distance* (Goffman, 1961) from chaplaincy and moving toward the role of spiritual care provider, some respondents manage to define their roles as healthcare professionals. According to Goffman, individuals do not always live up to all the behavioural prescriptions regarding their role because of a gap between role obligations and role performances. The following account explains how spiritual support is emphasized over religious support in order to establish their role as medical team member:

I tell people straight out that here I am employed by the hospital. I am not employed by my faith tradition, which means I am not representing them and just like the physicians and the nurses and the rest of the medical team here, I provide care to everybody whether they are religious or not and all faith traditions because it doesn't matter who you are or who you believe, being here as a patient or family member is stressful and I am here to provide care and support for people (Interview No. 15).

In contrast to the above examples, in hospitals where spiritual care is based on faith traditions, chaplains may be identified according to their faith (e.g. Catholic chaplain, Anglican chaplain, etc.), and the work is divided according to faith tradition so that each chaplain looks after patients of his or her own faith first. Generally speaking, it seems Catholic and Jewish patients are more comfortable with chaplains of their own faith. Accordingly, chaplains of these two faith traditions are more likely to carry lists of Catholic and Jewish patients, visiting them before other patients.

Areas of Concentration

Although they offer spiritual care for all patients, chaplains are usually assigned to specific units. The responsibility of looking after those patients who are in critical condition and are probably in need of care more than others is carefully divided between the chaplains of a spiritual care department. Since for most hospitals it is not affordable to hire enough chaplains to cover all parts of the hospital, usually units with critically ill patients are given priority. In most hospitals from which I recruited chaplains, units with regular chaplaincy services included Palliative Care, Emergency Department, Intensive Care Unit, Coronary Care Unit and the like. Patients hospitalized in other units can benefit from chaplaincy services if they request it, but chaplains may not regularly visit units for non-critical care.

Unpredictability

The work of hospital chaplains can be characterized by its unpredictability. Chaplains may have a fair amount of freedom in their work schedules because their

services are for different people in very different situations. Some of them have options as to what time to arrive and leave work. This is partly because of the diverse and flexible nature of the job, which in the view of many chaplains is a great advantage. Spiritual support and care is not a medical treatment that all patients receive as a standardized procedure. Situations and encounters vary from one day to another. Emotional experiences, therefore, are very diverse and unpredictable. On a heavy or "odd" day, a chaplain may be stunned by several deaths or difficult situations and feel quite exhausted. On "normal" days, however, things might be calmer, giving the chaplain an opportunity to decide on the number of visits or the amount of time for socializing with each patient. Most of the chaplains in this sample believed there is no such thing as a usual day in their job. Even though there might be a certain amount of regularity, a certain rhythm, most of the time it is unpredictable. Even if she¹ tries to make routines and follow a stable pattern, a chaplain may be suddenly interrupted by her pager, which can go off at any moment, making it impossible to accomplish a predetermined plan. Although for novice chaplains or those in residency programs such a situation can be stressful, for most experienced chaplains it is a desirable advantage. As the following example indicates, there may be an *institutional scheduling of emotion management*, helping chaplains achieve a sense of stability at work. However, several respondents mentioned on-call work as their favourite, which is usually given to residents or novice chaplains, because it provides them with surprise and unpredictability:

I do have a plan; I have a schedule, but my schedule can be interrupted anytime by the pager and that's when I always feel very blessed; when my pager goes off, because I know I am being sent somewhere.....

¹ Throughout the text I use the female pronoun to refer to chaplains even though a few of my respondents are male. Although the majority of the sample is made of female chaplains, I do mean both genders when I speak about a chaplain.

Interviewer: And you like that?

Chaplains: I love it! Love it! Yeah, there is no greater joy than to have my pager go off and not knowing where I am going and the more challenging the better... (Interview No. 17).

In the case of chaplains who are also in managerial positions, things are more regular. There might be more of a balance between stability and unpredictability and chaplains may become involved in *routines* as an active strategy to keep a balance:

I try to have routines. My position is changing here right now, because I have been an administrator and the director of the department, I oversee everything. I coordinate everything. And I don't see as many patients as I used to, and I don't.... not as much as like to, but I had a chaplain leaving us just over a month ago and it is changing the dynamics in the department completely so I am seeing more patients now and I think when you are more involved with patient care your day is even more unpredictable. So I would put meetings in my calendar, you know, like if you would have come today and I am the only chaplain on duty and then a crisis happens I have to say: "I am sorry the interview is over, I have to go," and that happens frequently when you look after patients and you are involved in crisis work (Interview No. 12).

Hospital Rounds as Case Finding

Most of the chaplains start their day by checking reports or voice-mail messages from chaplains from the night before, who are often contractual, on-call chaplains, to see if there has been a change (positive or negative) in the situation of their patients. Sometimes, all staff chaplains meet in the spiritual care department for a prayer to begin their day. Depending on the procedure in each hospital, they then join other medical staff, the so-called allied health colleagues, for rounds in assigned units to check on their patients. They have a list of patients in their unit, which is usually printed off and carried along. In some hospitals, chaplains may go to rounds alone and see what is going on. In any case, it is through these rounds that chaplains evaluate the spiritual needs of their

patients, already hospitalized or newly admitted, and later in the day decide to spend time with those who are most in need of spiritual care. As one chaplain mentioned, "with rounds I have my pulse on the whole floor" (interview No. 16). For another chaplain, rounds are a sort of "case finding" through which:

I can find out who are newcomers, if they need a chaplain to be there, what's going on, if there has been any disappointments or if they've personally had some grief recently" (Interview No. 7).

Another chaplain described rounds as a way of "sort of flagging patients" (interview No. 8). Chaplains may receive referrals from other medical staff who think spiritual care is useful for a particular patient. Since it would be impossible to visit and spend extended time with all patients, chaplains tend to be careful in prioritizing their referrals as effectively as possible:

I get referrals and I might get them from care rounds and often the staff.... saying, you know, "I just think that this person would benefit from seeing you." And I don't usually go into a lot of detail because each team only has 15 minutes and they could have anywhere up to 20 to 30 patients, so we don't have time to go into anyone....and I always say to them that "I trust that if you have a sense that someone would benefit then..." Because ultimately I think everybody could benefit from having someone to talk to, but usually I'll ask them "is this person going to be here for a length of time?" If they give me a number of referrals I'd say "so based on the people you have given me this person is palliative so I'll see them." If they're imminently palliative.... if they are waiting for a nursing home, I might triage them further down because they're gonna be here over a number of days or weeks, so I triage them first that way (Interview No. 14).

The rounds usually start early in the morning (around 8:30 or 9:00) and can last from half an hour to 45 or 60 minutes. In encounters with new patients, chaplains introduce themselves and explain a little bit about their role and how they can be of help. If they already know patients, they may have a brief conversation asking how they feel today. Chaplains tend to be relaxed and use, whenever possible, a sense of humour.

Apart from rounds and referrals, chaplains also hold a diverse range of ceremonies, varying from memorial services for recently deceased patients to religious and prayer rituals for anybody who is interested, to debriefing sessions for the medical staff after a difficult situation.

Different Clients

In terms of the kind of clients for whom chaplains provide spiritual care, a distinction can be made among three categories: (1) patients, (2) family members, and (3) medical staff. Most cases are from the first group i.e. patients. According to the unit or the kind of hospital, however, patients may be second in order after family members. For example, in Intensive Care or Neuro Surgery Units, where patients are unconscious for the most part, chaplains spend more time with family members and attend to their needs. Likewise, in paediatric hospitals, the work of chaplaincy is primarily concentrated around parents and family members of the sick children rather than the children themselves. Medical staff are always in third place. Even though there are chaplains whose job is to provide spiritual care exclusively to medical staff, almost all chaplains I interviewed worked first with patients and their families, and only secondarily with medical staff. There is no common pattern to provide support for medical staff on an individual basis. Chaplains do have encounters with individual doctors and nurses who come to their office for support, but this is not primarily how they give support to medical staff. Instead, when there is a difficult situation, chaplains hold debriefing sessions in which medical staff can participate and receive support. Sometimes there are regular weekly sessions to talk about difficulties and stresses at work. It is through these sessions that

medical personnel benefit from chaplaincy support. Individual interactions with medical staff are rather erratic and occasional, happening only when a pressing personal problem occurs.

Emotional Clients

The situations in which chaplains meet with patients vary from day to day and from one hospital to another, but they all share one basic commonality: being filled with emotion. In other words, chaplains often find themselves in situations where they have to deal with a group of people (patients or family members or even medical staff) who are going through intense emotional experiences, experiences that can be suffered silently or conversely, displayed in a variety of expressive ways. When asked how frequently they encounter patients or family members who are overwhelmed with emotion, behaving in expressive or even hysteric ways, most chaplains said if not on a daily basis, at least several times in a week. They may not encounter people who sob loudly every day, but interaction with crying or tearful individuals happens daily.

While most people in need of spiritual care are in fact overwhelmed with emotion, the frequency with which chaplains encounter emotionally expressive individuals varies according to three factors: (1) the type of hospital, (2) religious and ethnic background, and (3) type of disease. I will describe each category below.

When people are struck by life-threatening accidents, or a serious health problem hits their loved ones unexpectedly, the emotional response can be hysterical. Extreme expression of this kind is more frequent in hospitals where critically ill patients are admitted. Two such hospitals are available in Toronto. I was able to recruit respondents

from both of them and the interviews I conducted with these chaplains are filled with illuminating examples of the kinds of situations with which a chaplain may have to deal.

Consider the following example:

This is a few years back, it was an electrical accident; a young guy who was in his early 20s was electrocuted on the job and brought to our emergency department. Of course he was dead on arrival, but meeting with his family members for the next four hours... they were screaming, they were crying, they were shaking him telling him to wake up, to get up. They absolutely could not believe it; his fiancée was there, they had all sorts of plans for the evening and his mother and father and the thing is that people kept coming in because he had a large family, he had extended family, many friends so for four to six hours I was with them and there was no ministry that I could do except to love them and to listen to them and to be present to them... (Interview No. 17).

How expressively people display their emotions can also be influenced by religious and ethnic/racial background. This is an interesting finding, which seems to be in harmony with the view social constructionists hold of emotions. As discussed Chapter Two, those sociologists of emotion who support social constructionism, including Hochschild, believe emotions are shaped by the cultural norms and feeling rules of each society, dictating how people should experience and express different emotions. In a hospital where spiritual care was provided according to faith traditions, the Catholic chaplain who visits primarily Catholic patients, and the Anglican chaplain who visits patients primarily with an English background, provided quite different answers to the question that asked how frequently they encounter hysterical patients:

Catholic chaplain: Because I am the Catholic chaplain I get a lot of patients who are from the Mediterranean, and they tend to express themselves in a more extroverted way than in general, than some other cultural groups. So I had an Italian family, maybe two weeks ago, where the elderly grandmother died and her sister came in to the room. She was in her 70s and as this small, very overweight, woman walked in to the room, the daughter says to her aunt, in Italian, you know, "mama died" and – I am not kidding – I kept her from falling to the ground. She almost fainted... (Interview No. 2).

Anglican chaplain: Not a lot... there are two lists of patients that I do not carry on a regular basis. Doesn't mean that I don't see them, but I don't carry the Roman Catholic list and I don't carry the Jewish list, I carry everybody else's. I wouldn't automatically visit those two particular faith groups...what I am left with are basically western Europeans and a whole whack of folks whose background is British, they don't tend to get overwhelmed, they don't do that. My first experience having a family do that was at another hospital because there I saw every patient, and there were families of Thai background, Greek background, and I was...it was...that was a cultural shock to me.... (Interview No. 3).

In hospitals where the presence of ethnic minorities is not obvious, or chaplains do not have frequent interactions with multicultural patients, the following observation may be reported:

The sense of overwhelming is really common, but acting out is fairly rare. I know that big drama would be less than once a week. Even though situations are very serious, people are dying, most people are fairly self-contained in some form or another, either because there is a cultural expectation around how they'd behave or.... they are just too sick. There is not enough energy to create a big dramatic affair..... (Interview No. 8).

In the view of one chaplain, lack of emotional expression is a problem in North America, which can prevent people from releasing their pain:

You can shout them up...they [family members] are feeling real pain, real grief, just because in North America everything is whitewashed and this thing....I come from India...you would yell and cry and everything...people from Africa like that...the Irish, you know, they make a big noise, Italians make a big noise so ultimately who is it who doesn't make a noise? It's only people from here... (Interview No. 9).

Another chaplain believed norms regarding the display of emotion are different among different groups. Having first-hand experience of working with various ethnic groups in one of the most multicultural hospitals in Toronto, she believed everybody feels emotions, but they may express them differently. While criticizing North America for an

individualist culture, she nonetheless believed it is not fair to say North Americans are unemotional. They just express their emotions differently:

There is a lot of...there might be a lot of crying, a lot of saying like: "I don't think I can"—but they would express it—"I don't think I can keep standing, *I'm feeling dizzy*," and that's because they are *overwhelmed*, you can't stop that, you have to just let it happen.... (Interview No. 3).

The above example provides a phenomenological interpretation of emotion. The chaplain identifies emotional experiences through verbal explanations and how they are felt in the body. The phenomenological approach emphasizes feelings of self and the relationship that one has with one's self and with one's body. By looking at verbal explanations of feelings (e.g. feeling dizzy), the chaplain was able to evaluate a patients' emotionality (e.g. overwhelmed).

Apart from racial and ethnic background, religion can be also an important determinant of emotional expression, especially when, beyond a mere ideological doctrine, it is embedded in cultural, social and family life. The following account indicates that emotional deviance may vary according to, and be influenced by, cultural and religious norms:

We had a Jewish patient who died and another Christian patient who died sort of the same time and I went to deal with the Christian family who were angry because of the situation but they weren't lashing out; they were voicing their anger in an appropriate fashion and the manager was able to come and speak to them and find out what their concerns are and I stayed with them until they were ready to leave. But the family of the Jewish patient who died were yelling and screaming and being very demonstrative of their grief.... I called the Rabbi to come and he was able to come and be with them. With his presence they were able to cope with what was happening better..... (Interview No. 12).

In fact, the only Jewish chaplain in the sample mentioned that some of her patients are in the geriatric area and so the family members know the status of their loved ones.

Yet they could be quite unprepared for bad news: “even though the staff has given them the information they are still unprepared” (interview No. 21).

Emotional expression can also differ according to the kind of diseases patients suffer from. Chronic diseases, even mortal ones (e.g. advanced cancer), produce a whole range of lingering emotions. Once the initial shock, in which the patient is informed of the existence of the disease, has passed, the subsequent emotional experiences are rather long lasting, and rarely expressed in terms of a sudden outburst. As one chaplain working with cancer patients explained: “people with cancer usually worry about their families, the fear that what is going to happen next; is it treatable or is going to kill them? Etc.”(Interview No. 13).

Such a condition produces fear, anxiety and uncertainty. Coupled with sadness, frustration, and anger, it can put the patient in a depressed mood, which is not helpful for a successful treatment. If the illness advances and leaves no hope for a cure, the patient will be transferred to palliative care, where he or she is looked after not in terms of a cure, but rather for reducing pain and discomfort. Meanwhile, family members and patients themselves may become better prepared for the final stage, which in most cases is, alas, death.

The emotional experiences of patients with mental-health issues are also similar. The only Muslim chaplain in the sample, who was manager of spiritual care in a center for mental health and drug addiction, believed being a patient in a psychiatric hospital is itself an overwhelming, ongoing, emotional state. It is not normal for anyone to be hospitalized. However, being in a hospital as a result of mental illness carries an additional stigma:

Clients that we serve have this kind of ongoing emotional, you know, – the nature of the illness – ongoing emotional discomfort, whether it is dealing with hallucination or delusion, schizophrenia or depression or anxiety, you know. I think that is an ongoing situation.... (Interview No. 10).

Hospital chaplains in Toronto are required to deal with different kinds of situations and with people from different racial, ethnic, religious, and cultural backgrounds. Given the multicultural nature of Toronto, medical settings in this city are excellent places to study the cultural patterns of emotional expression among an internationally diversified range of people from all over the world. It is also interesting to see how such multiculturalism shapes chaplains' theology. As a result of dealing with people from many different cultures, Toronto-based chaplains have become such liberal, open-minded religious individuals that one wonders if they ever feel offended by anti-religious remarks. None of the chaplains said they would be angry if a patient insulted their religion. Even though some were quite conservative and meticulous when it came to their own personal observances and rituals, all chaplains expressed a warm openness in dealing with other religions. By adopting a high tolerance for other theological views, they seem to be among the most open-minded and non-judgmental religious people, fully aware of the maladies of religious dogmatism. By working in Toronto hospitals, where they are likely to meet people from all over the world with different religions and spiritual inclinations, these chaplains have learned to be open-minded in their own religious and theological views.

Interaction with Emotional Clients

In times of crisis when people are extremely emotional, the first issue is to provide safety. In a damage control process, a chaplain may ensure a family member not hurt

herself by “hitting her head on the floor or cutting it” (interview No. 2). Sometimes, the safety of the chaplains themselves could be at risk. Even though such occasions are rare, a chaplain remembers:

I was in a situation where somebody was so desperately upset about the death of [her] husband that [she] was striking out actually physically and whipping around and the security staff didn't want to touch her; so they thought calling a chaplain might be a good idea...I think it would have been better if they could call earlier before that started, but that was neither here nor there, so she was actually hurting me...and so...mixed emotions are one of the hardest things, so on the one hand I wanted to protect myself and say: “do not do that,” but on the other hand I was aware that in the next room was her husband who was dead from a car accident, so that's desperately awful....

Interviewer: What did you do?

Chaplain: What did I do! Umm, I *held my tongue*, which is not easy, so I stopped that. I did not express my anger verbally but I did hold it *physically*, and I told her that I couldn't help if she was gonna hit me, because I wanted to sit with her, so I try to *appeal to my own sadness* to express that, but you have to be able to think and feel very quickly.... (Interview No. 3).

“Holding tongue” is a bodily technique of emotion management (Hochschild, 1979) employed by this chaplain to suppress her anger. As she mentions a few sentences later, she holds her anger physically and tries to transform her feelings by a reflexive role taking process in which she “appeals to her own sadness.” She then engages in what I call *strategic submissiveness* in order to perform interpersonal emotion management. By moving close and saying “I can't help if you are going to hit me,” not only does this chaplain acknowledge her patients' emotional state, but she also expresses her determination to reach out and help, even though it might be dangerous.

In a similar example, a chaplain felt threatened where criminal violence was involved:

I was never scared earlier because it was like, you know, security is there. I trust God and, you know, I do my work, but one case I had where this young

man was shot and he was known to the police; he and his brothers were known to the police and they.... all came and circled me, his brothers, his...like, rough-looking black guys, you know, and they don't care, you know, they slap you..... (Interview No. 9).

In such cases there needs to be a very quick evaluation of the situation. Since the safety and well-being of other patients present in the room is also at stake, individuals who make a lot of noise or behave in threatening ways, are politely, yet assertively, asked to leave the situation and go to a private room where they can freely express their emotions. One chaplain remembers:

There was a family member at the bedside of a patient who had died and she was hysterical and there were other patients right beside and it was an open area and finally I literally, you know, I held her and I came very close to her and I said: "listen, you need to come with me to the back room because there are other patients and they are sick too and I need you to be able to do what you have to do"... (Interview No. 15).

Similarly, another chaplain explains:

We take them [hysterical family members] to a quiet room, where they can be emotional because you always have to consider the people in the other bed or the other room...I don't have any trouble with emotions because whether you are happy or sad, it's not good or bad, it just is. Emotions are emotions, right? So I don't have any problem with whatever emotions people are feeling, but sometimes other people do, and they get distressed and if I am a patient who is dying of cancer and the patient in the next bed just died and their daughter is yelling and screaming and falling on the floor, then your anxiety rises, you think this is gonna happen to me, you know, so for the sake of the other patients I would want them to stay calm, and I want to help that family member either find a way to gain control of themselves again, or to find a *safe place* for them to go and just let it all out (Interview No. 12).

As the above examples indicate, chaplains may find themselves in situations where they are empowered to demand for an instant that patients or family members control their emotions. In such cases, the purpose is first to protect the safety and well-being of other patients and then provide a safe social space for emotionally overwhelmed individuals so that they can release their emotions without disturbing others. When hysterical behaviour

is over and things have calmed down, a chaplain's main work starts. This is when the importance of communicative skills and interactional competence (Cicourel, 1973) in developing relationships is emphasized. It should be emphasized that in most cases, Canadian chaplains do not have to deal with hysterical individuals, but rather ordinary people (patients and family members) who are caught in an emotional state or a combination of mixed emotions. How do they approach such people? Chaplains are professionally trained to help people understand what they are feeling. In a process of intense emotional engagement, a chaplain may have to be thinking back and forth between her own emotional history and a patient's emotional experience, trying to identify what is going on in the patient's emotional world. Modifying Schweingruber and Berns's (2005) notion of *emotional bridge*, I describe this process as *interpersonal emotional bridge*. In their study of occupational emotion management in a door-to-door sales company, Schweingruber and Berns realized that salespeople are trained to develop a potential emotional capital, connecting their previous self to the new self that is being developed on the job.

Prepared to initiate interactions with competence, chaplains need to be able to provide a safe social space. In doing so, they engage people in conversation not by asking too many questions, but by listening to them in such a way that people feel safe to open up and talk about whatever that is important for them. In many cases, people are carried away with grief, sadness, anger, frustration, helplessness, fear, anxiety, etc. and need support. Once they are allowed to express their emotions, it becomes possible to recognize and name them. The following account provides an example of how a chaplain,

competent in dealing with angry patients, gets around a patient, starts the conversation and changes a sad situation into a funny one:

There was a gentleman who was.... he was sort of paranoid, he was presenting as very paranoid to the nurses and he was lashing out at them and so they called me and asked me to sit down and have a visit with this gentleman and within a few minutes I said, well, you know, "do you have any spirituality or something?" "Oh, I am Christian, yeah," he said. Then I said: "well, I came to know the Lord and I got hit by a car," and I said: "when I was down there he got hold on me," and he started to laugh, he started to laugh in some silly...and I said, "yeah, I am just like St. Paul," and I was talking about the Bible and he says: "Oh, I know those guys very, very well," and, you know, we were laughing so hard and he said: "Do you think we are disturbing some of the other patients?" I said: "I think they need a laugh too" (laughter), so he became really happy... (Interview No. 17).

Through these conversations, chaplains look for the resources people have at their disposal or resources they have used in the past in order to help them go through a difficult time in the present. A good example of this comes from the Jewish chaplain, who often encounters Holocaust survivors:

I notice something about them [Holocaust survivors] and I ask them: "where were you during the war?" and they would tell me the stories and that helps them not so much [in] living the horror of the time but focusing on the strength that they had to survive at [that] horrible time and sometimes those areas of strength help them refocus on those aspects that can get them through the current difficulty (Interview No. 21).

In the case of religious people, it could be their faith and their relationship with God or the Divine Force that give them strength. In the case of people with no religion, the emphasis could be on spirituality. Defined in general terms, spirituality can be anything that gives meaning and purpose to life, a force or connection to the universe. One chaplain remembers how she dealt with an atheist patient who did not have any religious affiliations, yet wanted spiritual care:

I had a patient years ago who was confirmedly an atheist, but he wanted me to come and visit him everyday..... When he died, his memorial service was at

the gym that he worked out in every single day. He was there six times a week and that was his community of friends and those were the people who gave him support and that was the place where he found himself most. So his widow said they have a room there for a memorial service for reception. So that's where they did that, which is much more authentic for him if he didn't want to do it with a Christian God, you know, and didn't want to have it in a church (Interview No. 2).

Chaplains may ask different questions to find out what is most significant for people during hospitalization. Conversations, therefore, are very context-specific and different from patient to patient. Using an ethnomethodological perspective, we can see how chaplains establish a kind of *contextual spirituality* which is related to the spiritual orientation of each patient and the specific context in which conversations take place. In describing the spiritual aspect of his job, one chaplain says:

This [job] is to take spirituality from that sort of abstract, very in-your-head kind of spirituality and put in down into a living, concrete..... Because a whole bunch of nice ideas, well they are just a whole bunch of nice ideas.... (Interview No. 8).

While for many people talking about music, beauty, nature, art, family, etc. is charged with spirituality, conversations can develop around small things, such as a pet bird. The following account explains what was said by the previous chaplain:

Dorothy was a 92-year-old woman in Dialysis Unit; she used to come in three times a week... She told me she lived alone. She had a little pet bird and her pet bird was her life and she [would] tell me stories about her bird and tell me stories about her life – how she used to play baseball, she was very sport minded and, you know, I just loved Dorothy..... (Interview No. 17).

The chaplain working with cancer patients commented:

I look to see, basically, to explore where they are at, you know, what emotions they are exhibiting, providing them an opportunity, a support of presence, I guess, is that how I would term it: to listen to them and provide that *listening support type of presence* for patients and their families and explore what resources they have had to help them cope with overwhelming situations in the past, right? You know, support of family, support of friends, support of their faith. For those who have a faith background often faith is very important

as a source of strength to provide some sort of meaning in all of this and for those who have no faith, for those who practice no particular faith, then basically again to explore who they have or what they have as a means of support to go through the journey... (Interview No. 13).

The “listening support type of presence” is hardly analogous to a usual conversation. In other words, it is very much emotionally charged. Chaplains need to establish intimacy. Not only should they be emotionally present and attentive, but they must authentically care about their patients and sympathize with them. One chaplain put it succinctly: “unlike the other people in the hospital who have more technical jobs, it is emotional presence that we have to offer” (interview No. 8).

In a process described by other researchers (Wright, 2000) as “active listening,” chaplains may use specific words, body language and sometimes physical contact to engage people to talk about their feelings. Several techniques of interpersonal emotion management are involved in such listening. Explaining how she tries to establish rapport with patients, one chaplain says:

It would be through the use of physical space, moving my chair closer down to be at eye level with them. It might be softening my voice; it could be touching them or it could be simply letting them cry without trying to stop it and without trying to fix it.... (Interview No. 15).

Another chaplain answers to the same topic:

By the way I hold myself, like the way I sit in a chair, the way I lean forward, the way I make eye contact, the way I don't make excessive eye contact. You don't want to [be] staring people down, right? You have to create a container that they feel safe in and that they can pour their story into.... (Interview No. 8).

Another respondent talked about the strategy she uses to convey to her patients that she is careful and attentive:

When we talk, whatever they have said to me, I will gather together so that by mentioning all those things they know that I have heard them and that is held up in prayer for them.... (Interview No. 9).

One chaplain, in particular, talked about the importance of holding hands as a way to connect to people. Interestingly enough, only a couple of chaplains said they would use physical contact frequently:

I might get a chair, I might sit with them. I am a toucher; I am a hand holder; I don't think I am doing anything inappropriate but I do that automatically. If I felt that somebody was like [disapproving] I obviously am not going to do it, but believe it or not, almost all people find that comforting; there is a connection there, and it also means that I am not telling them to stop [crying] because that's really unfair...

Interviewer: It helps them to release the accumulated emotions and tensions....?

Chaplain: Yeah, and for me to be able to sit with them. I think that sends the message that, that it's fine and that they are in the safe place, and everything they have is very real....(Interview No. 3).

Another chaplain provides an insightful account, which is very similar to some of the examples that Goffman discusses in *Stigma* (1961). Goffman used a similar example to discuss the stigmatization of physically defective patients:

I often use [physical contact] by asking permission first. In terms of cancer patients, sometimes it's the human touch that means the most to them. Everyone who comes to see them are either in gloves to do a kind of procedure or sometimes they feel untouchable like, you know, "does no one love me anymore?" I can remember one patient, in particular, who had bowel cancer and who ended up with a colostomy....that was really, really unpleasant and this particular patient really felt unlovable. The first big thing for her was her husband: "will my husband and I be able to be intimate with each other ever again?" Because when you look...when most people look in a mirror they see their body and they don't envision themselves having a bag under their stomach, right? This particular patient was very social, was very involved in her community and had big groups of friends; she was [an] extrovert for sure. And all of a sudden started to think: "oh my goodness, how am I going to be in public with this?" Because often if you have a colostomy sometimes it makes sounds, right? You can't control, you know, so she was worried about, you know, suppose I go to theatre and all of a sudden my

colostomy acts out with all kinds of sounds or suppose someone can smell something from it, so those were all different concerns for her and they were overwhelming, you know, and in that particular case I think being touched either by, you know, holding her hand or giving her a hug was a way of demonstrating that you are the very same person you have always been. It's just you can't help what's happening, you know, so it was important to that particular person to be physically touched (Interview No. 13).

The process of interaction with clients, therefore, can be summarized as follows: equipped with interactional competence, chaplains enter work situations and initiate conversations in which they take the role of an active and attentive listener rather than a speaker. As soon as they can provide a safe social space where people feel comfortable to open up and talk, chaplains start working on contextual spirituality, that is, exploring whatever spiritual, religious or other inner force that is available to patients and can give them power and strength to cope with the situation or come to terms with it. The most important component of this mechanism is identifying and releasing emotions, a process that includes multiple techniques of self, as well as interpersonal, emotion management. One respondent metaphorically described this as *emotional vomit*:

If your stomach is unsettled and you vomit, it's not pleasant but you feel better after, and if your emotions are unsettled and you are able to get them out through tears or some expression, then people usually feel better after.... if you can imagine your stomach is upset, you are trying to vomit and somebody is telling you, stop and try to make you close your mouth and try to keep it all in, that's harmful; so [my job is to] give somebody space to do what they need to do and there are times when I need to protect that space because other team members are often coming in, so if I am with a patient or family member and they are upset, they are crying just in a very emotionally vulnerable place, you know, I have had times when there has been a team of six doctors who have just kind of whipped open the curtain and interrupted and I was like: "I need two minutes, please, you need to wait," because it's as vulnerable as if the nurse had the dressing off and they were doing a dressing change... (Interview No. 15).

This example reemphasizes the importance of a safe social space and privacy in facilitating emotional release. Another respondent described this work as *process*

feelings, which is another name for interpersonal emotion management. When a chaplain sees tears coming up, it is a sign of her success in gaining trust and providing a safe social space to help her patients realize what is hurting needs to be brought to the surface, verbalized or otherwise expressed. Patients should not feel afraid, uncomfortable or shy to reveal their emotions:

When people are crying with me – and I often tell this to them – I feel honoured that they felt safe enough to shed their tears with me; because if people don't feel safe, they'll make me leave and they'd cry in the bathroom... so when people cry with me I feel like they hand me their heart and I am holding it for them as they are in that place of pain.... (Interview No. 18).

In addition to the previous techniques, chaplains may also perform specific rituals to facilitate the release of emotions, such as the one performed by a multi-faith chaplain at such critical moments as death and dying:

I have a ritual that does not necessarily reflect Christian principles. So a blessing of eyes, ears, nose, mouth, hands, feet, and heart...

Interviewer: Of the dead person?

Chaplain: Or the person who is dying. I can adapt it for a person who is dying and if the person has already died. And I used that ritual a lot and it's helpful to people. So I give them a leaflet. I have it in print so that they have that in their hands. And they are part of it. They can raise their hand over the person in blessing at the end. Depending on the family, if I feel the family is involved and accepting the fact that the person is dying, there is response after each of those blessing that can be: "You will always be a part of heart, go in peace," so it doesn't.... I don't use that all the time, and it depends on who I am with; I don't have to have that at all. There is a part if I want to use it – I say to people if you want to thank this person for something you can say it in whisper, you can say it aloud or you can say it in the silent of your heart. We will just pause. So different things, depending on the situation (Interview No. 4).

Several chaplains said they try to *validate* whatever feelings their patients are experiencing, giving them permission to express what is going on in their inner self.

Although interventions vary from one person to another, chaplains encourage people to express emotions because:

It's not helpful to just push everything down and so when tears flow I actually see that as a sign that they [patients] are ready to do some shift, and when the tension is relieved then there is the opportunity for them to make new meaning around what they are experiencing. But the first thing, if they can, is experience their grief and work on their grief. That's a very valuable process (Interview No. 8).

In a similar vein, one respondent says:

My intention when working with people is to help create a safe space where people can experience their emotions intensely, feel them deeply.... that would allow some movement and healing to happen and insight to come; so great, if somebody feels safe enough that they can allow emotion to be expressed and deeply felt in our work, that is great (Interview No. 19).

All these examples indicate the importance of identifying, naming and releasing negative feelings. Whether it is an undirected anger over a situation one has no control over, or grief for loss of a loved one, the emotion needs to be identified and processed. In facilitating this emotional release chaplains rely on their interactional competence, but they should also rely on a diverse range of *strategic interventions* (Kenney, 2010: 194), which I described as techniques of interpersonal emotion management, including strategic submissiveness, rituals, validating feelings, providing a safe social space, and establishing contextual spirituality.

Dealing with Grief

Grief, in particular, is one of the most common emotions chaplains have to deal with. As a common phenomenon in times of loss, terminal illness, or death of a loved one, grief has been described under different names and different situations. For example,

Siegel and Weinstein (1983: 62) describe *anticipatory grief* as a process in which individuals confronted with the expectation that they will experience a significant loss in the near future begin the grieving process in anticipation of that event. Anticipatory grief has generally been viewed as a positive adaptive response to impending loss, presumably because it provides a person with an opportunity to rehearse the bereaved role and begin working through the profound changes that typically accompany loss, thereby mitigating the trauma associated with actual bereavement

In contrast to this type of grief, Doka (1989: 4) defines *disenfranchised grief* as experienced “when [people] incur a loss that is not or cannot be openly acknowledged, publicly mourned or socially supported.” Doka proposes that if grief is not socially sanctioned, it does not elicit the same degrees of support from friends, family or professionals, or may not even be overtly expressed. Disenfranchised grief is deemed inappropriate, illegitimate, unnecessary or irrelevant.

Yet from another perspective, grief can be described as *instrumental* and *intuitive* (Martin & Doka, 2000; in Marrazzo, 2008: 3). According to this analysis, instrumental grievers express grief through physical means and are more likely to intellectualize the experience. Intuitive grievers, however, are more likely to experience grief in waves of emotion, seeking social support to work through the grief.

Grief over losing a spouse can be very intense and devastating. Various referred to as the “broken heart syndrome” or the “loss effect” (Lynch, 1977), this type of grief refers to the grief that a surviving spouse experience as a result of loss. As Lynch argues, people can be subject to increased risk of dying following such grief.

Finally, in his study of survivors and victims of crime in Canada, Kenney (2010: 55) discovered different grief cycles among men and women. According to Kenney, survivors of crime experience gendered grief cycles related to traditional gender roles. For example, men often speak about being dominated by guilt in their grief process, because of a feeling of failure in their traditional protector role, whereas women, traditionally having more flexibility in emotional expression, become enmeshed in a focus on the child they have lost that becomes cyclical in relation to past and ongoing events. Men may find themselves in a matrix of negative emotions that Kenney (2010: 57) terms “guilt-repression-anger-depression” dynamic, while women develop an emotional feedback mechanism that deepens their sense of loss.

Distinctions between different variants of grief are important for the work of chaplains because their job is to identify and work through the grief of family members and patients. As one of the respondents said: “I would help them [patients] to name what their grief is and once they have named their grief, to find out ways for them to act on it” (interview No. 2). To be able to do so, another respondent said, “I tune myself to the grief patients are feeling” (interview No. 11).

By identifying and naming a certain type of grief, chaplains can better help patients or survivors of loss in their coping. For example, if parents feel guilty over the loss of their child as a result of their own negligence, they may have greater difficulty in experiencing legitimate grief. In such a situation, disenfranchised grief is more likely to be experienced than anticipatory grief. By normalizing and validating the feeling, chaplains can help such parents experience less guilt and more normalized grief. Similarly, in the case of terminally ill patients, chaplains can work with family members

to prepare them for subsequent grief. This work has been described by other researchers as “work of worry” (Janis 1958, in Siegel and Weinstein, 1983: 62). In his research on surgical patients, Janis realized that patients who performed the work of worry before surgery adjusted better after surgery. Janis’s research demonstrates the relationship between rehearsing a stressful event and subsequent coping.

Another way in which chaplains help people process their grief is by holding memorial services in the hospital for deceased patients. Such services can be therapeutic for the medical personnel as well, helping them grieve over the loss of a patient with whom they may have worked closely. In his study of funeral services in Newfoundland, Emke (2002: 274) describes hospital memorial services as “vehicles for emotions, as sites for expression and as physical markets for community solidarity.” Such ceremonies function as the memorialisation of experience, validating the grief rather than denying or dismissing it altogether.

Conclusion

As I have explained in this chapter, interactions between chaplains and patients are usually charged with strong emotions. In a process of intense interaction, chaplains use specific emotional expressions in their actions, words, contacts, etc. to connect with people, thereby creating a social space in which people feel safe to “pour their heart out.” The process of interaction between chaplains and patients start with interactional competence brought into the situation by chaplains. Once chaplains have established their role as spiritual care providers through active listening, they provide a safe social space in which a contextual spirituality can be cultivated to let patients draw on past or present

sources of strength in order to go through the immediate emotional difficulty. In this process, identifying, naming and facilitating the release of emotions are most important. In terms of Collins' (1981, 1990, 2004) *Interaction Ritual Chain*'s language, one could argue that such interactions happen in a market of *emotional energy exchange*, in which chaplains give emotional energy to those whose level of emotional energy is very low. In contrast to Collins's model, however, I would argue that such an exchange does not revolve around a stratified hierarchy based on power and status as two basic dimensions of micro interaction (Collins, 1990).

Interpersonal emotion management in healthcare is not usually reciprocal. In other words, healthcare professionals do not provide emotional care in the hope of receiving the same from their clients. A hierarchy of emotional exchange may be visible in physician-patient relationships (physicians' highly technical expertise may give them power over patients and their occupational/social role may put them in higher status). But in chaplain-patient relationships, this is not usually the case: chaplains provide their service to those patients who request it voluntarily. Looking forward to the indispensable expertise of the doctor, a patient may come in and out of the hospital without visiting the chaplaincy department at all. In fact, the exchange of emotional energy in chaplain-patient relationships could be termed *altruistic exchange* and chaplains may become involved in a type of emotion management that is *altruistic, selfless*, or, as Bolton and Boyd (2003: 300) call it, *philanthropic*. Such a selfless emotion management requires full dedication and attentiveness to patients' needs without expecting comfort or emotional support from them. Even though they may receive emotional rewards from interaction with patients, chaplains' emotional needs and comfort should be met somewhere else:

among colleagues and other healthcare professionals (e.g. psychotherapists). Deep engagement with people's emotions has consequences for chaplains. The following chapter provides a detailed description of the emotional challenges and difficulties that chaplains experience while doing their job. Interesting metaphors and expressions will be heard throughout the next chapter when chaplains talk about challenging tasks and difficult cases.

Chapter Five

Emotional Consequences and Challenges

Undoubtedly, to be emotionally present all the time, from one bed to another, from one family to another and performing *support practices* (Kenney, 2010:150), requires full dedication and commitment. One chaplain described his role like a *sponge*:

You are soaking up everybody else's emotions, like you have to be present for everybody, like even if you have a rude patient, like no matter how bad your day is, you still need to be attentive to that patient's needs, so when I am with a patient who has had a bad day, who needs to talk and is overwhelmed by all that is happening, I still need to be there and be attentive, and in that case it could be overwhelming at times....(Interview No. 8).

Such situations are, by nature, energy draining. Going into a situation, a chaplain must be prepared for some form of emotional breakdown or another:

If I am going to a family meeting I bring Kleenex because I almost know there's gonna be a breakdown at some point, because usually the family meetings I attend to are about palliation or the family meeting is about not putting in a G tube or it's something like going to another facility, so it's hard; there are very difficult situations.... (Interview No. 7).

Sometimes situations are particularly challenging when a chaplain has to deal with two opposing extremes. Talking about the notion of *emotional elasticity*, one chaplain remembers how exhausted she was after moving from one room to another:

I remember one day in one room I had a patient and their family who were over the moon because they were getting a transplant that day, so I have been visiting this patient for some time...They were very happy and anxious too, but it was like "our waiting is over, the organ is coming," so they were very excited; and in another room there was a family where the patient had been very sick and it was unfolding to them that the patient was gonna die and so going from extreme happiness to extreme sadness literally within five minutes...that was really, really challenging. And I went back and forth throughout the day, you know, between these two families and the emotions in the family of the patient who was dying...one family member had been hopeful that everything is gonna be fine and they had that realization that no, they are not coming home and they wailed and I was so emotionally drained when that family left; I burst into tears with one of the nurses in the room and

that had never happened before and it was just...I was finished, I was exhausted and.... it was very...having to travel very far emotionally, very quickly. I thought [it was like] being on an *emotional yo-yo*, you know, between happy celebration and intense, intense grief (Interview No. 15).

In order to understand a patient's story, one respondent believed that chaplains need to draw on their own emotional capital. In her view, chaplains cannot separate patients' emotions from their own:

Well, it's hard because some professions are trained to separate, to put your stuff upon the shelf, but as chaplains, we are trained to go into ourselves and to use ourselves to connect with that person like we are the tool. So we have to use ourselves; you can't escape being in touch with your own feelings. This gentleman I was just sitting with this morning, his mom is dying. My mom died two months ago, so I was very aware as he was talking about his mother. What is that...what is that like for me and so I don't tell him necessarily my story...we are not supposed to...my job is not to get to my story, my job is to help him with what is happening, but I could use my feeling to be in touch with his feeling. If you are in a situation where, for instance, somebody's 20-year old daughter is dying – I am a mom, what would that be like to lose my daughter? I use my imagination to think what that would be like... (Interview No. 11).

As the above example illustrates, chaplains use their own experiences and memories as a kind of *emotional transmitter* to not only connect with people, but to make an interpersonal emotional bridge, understanding what people are going through. Even though their professional training educates chaplains to separate patients' emotions from their own, sometimes situations are so touching that it is impossible. As we will see in the following pages, emotional identification and over-identification with the situation can be a problem, creating active, ongoing tensions between emotional expression and role separation:

You know, we are taught don't get them [patients' problems]. That's nonsense; it does become part of you; some of the stories, not all, and certain cases just stand up. There is one case I don't think I will ever forget; this young girl, she was 16 years old, she was brought in on a Friday night, her mother had died in the accident, her uncle was also brought to Sunnybrook,

she was brain dead already...the mother and the daughter from BC, they came here to visit with the mother's brother...then they couldn't find the father. He was in BC and he doesn't believe in cell phones and things like that so he was very difficult to get in touch with and it's a mountains territory where they lived, but then they started phoning around everybody because they had to come. On Sunday morning they tracked him down, Sunday night he came and we had this family meeting where they had to decide what they were going to do and the family decided that they would donate her organs, so five families benefited from that, so they lost their child and that will always be...but the generosity was really great, so things like that I can say I will never forget because I was very much with that family throughout the whole thing. I finished my shift on Monday morning but I asked the chaplain of that unit – I said – “can I just continue to be with them?” Because it seems so incomplete and she was okay because for her jumping now was challenging, but I already connected with all of them in the family because 14 or 16 people came from BC and from The States, so I really got close to all of them. So then finally I remember 4:30 in the evening it was when we left because she was taken to the OR and they...that one family was really allowed....we have two bridges that connect the Critical Care to the OR glasses thing so we call it The Bridge of Size, you know, it's kind of the last walk but they were allowed to go right up to one end – They don't allow all families but somehow the fact that she was only 16...it just touched so many of the nurses and the doctors..... (Interview No. 9).

Similarly, another chaplain comments:

There are times when some of the situations affect me and they are more challenging than others. So cognitively I know I am not going to be grieving this person like the family is but still when I am driving home from work if it's been a very challenging day, you know, I am thinking about it or I sometimes lie awake at night and I am thinking about it... (Interview No. 15).

The problems that chaplains are bothered by are not always of a medical or clinical nature. One respondent surprised me by mentioning the parking fee as one of the most disturbing problems she finds among her patients and families. Adopting a holistic approach, this chaplain looks at a patient not in terms of a mechanical body with medical problems, but in terms of a human being whose circle of problems could be multi-dimensional and “enormous.”

If you sit and think about it, like the *enormity* of what a family has to put up with; they don't have the money....like this place doesn't have its own parking, they charge so much.

Interviewer: For the parking?

Chaplain: Yeah, it's, you know, when patients are lying here day after day, families cannot afford to come and pay 18 or 20 dollars per day for parking. It's very hard and so some of them are not able to come every day. They want to come but they can't because they put food on the table or you pay for the parking or they try to come, you know, if somebody give them a ride then they have to wait how to get back. I think some of it is painful to see...those who have cars and those who have money won't even understand that but we feel and we see a lot of it... (Interview No. 9).

Having several deaths in a day or seeing certain tragic cases happening repeatedly can be overwhelming. However, for some full-time chaplains, the workload in a week is a burden in itself, no matter how many difficult cases are involved. The following two examples explain, from a phenomenological perspective, how certain types of emotionality are experienced and lived through body:

What would normally happen is you come at the beginning of the week, you're pretty ok, but by the time you go home on Friday; I have often found – now nurses do this too – but I have often found myself not answering the phone. I just sit down and kind of veg out in front of the TV set– not a very healthy thing– and then I would have several drinks, you know, and you feel a little bit better Saturday morning and by Sunday you are feeling fine; you come in Monday morning full of enthusiasm.... so that's a pattern that is not a healthy pattern but I know lots of people... nurses I say – I would have good talk with nurses – and they say the same thing...they...at the end of their three-day shift, they don't want to talk to anyone; they don't want to see anyone; they just want to hibernate in some ways....(interview No. 5).

Another full-time chaplain talks about her job when it becomes draining:

I think I internalized a lot of emotions....I feel numb in my stomach, I feel very fatigued....a lot of times when you are in the situation you get a shot of adrenalin and you are there and you are thinking: "what do they need right now?" "What can I do?" You know, "should I be addressing this person?" I am thinking a lot. After the fact it's just so tiring, it's physically and emotionally draining... (Interview No. 7).

Spiritual Approach vs. Medical Approach

One important source of emotional conflict may come from different attitudes that chaplains (as spiritual care providers) and doctors (as medical care providers) hold toward patients. In Chapter Two, I talked about the role and significance of hospital chaplaincy. I argued that hospital chaplaincy developed to look after the nonmaterial or spiritual side of the human entity in response to the unprecedented development of modern medicine, which tends to look at patients in an impersonal, technical way approaching their bodies as machines and treating them with a kind of detached concern. A few chaplains in this study said their most extreme sense of anger and frustration stems either from medical decisions being made by “clinical” staff or the way that some medical personnel, including nurses, treat patients. Here I mention two examples, which I found personally disturbing. Before telling their stories, respondents were guaranteed confidentiality. I appreciate their openness in sharing these stories, which I believe demonstrate how difficult some of the situations in which chaplains work are.

In one case, a full-time chaplain talked about the case of a dying man, who was given morphine in order to depress his respiratory system. As his family requested, the medical team gave him morphine, took the breathing tube out and expected him to die shortly. However, it turned out to be more difficult than it was planned. The chaplain remembers:

I didn't feel he was being given enough sedation to make him comfortable at this time...you give the morphine and it depresses their urge to breath; at the same time you don't expect someone to live gasping for air as they die...doesn't feel very kind to me...umm....and I held that man's hand for over an hour and the whole time...I negotiated meanwhile for more morphine and I kept saying: "This man is in pain, he is uncomfortable, he needs more morphine"... "Well, this is all we can give him" and things.... you know, they were very clinical, both the nurse and the doctor were very clinical in this

instance. I was very angry with them and this man was... he just... he wasn't awake exactly because as I was sitting he was partly there but the way he held, he *wrung* my hand for that whole hour....

Interviewer: He was struggling....?

Chaplain: He was struggling to breathe. It was very uncomfortable for him and I knew that they weren't going to be giving him anything and I knew he was gonna die very slowly and he did die. I went home at 4:00 o'clock in the afternoon and he died about 4:00 o'clock in the morning, so he had, as far as I know, 12 more hours of discomfort and that really bothered me, I guess because of the physical discomfort of the whole thing... (Interview No. 5).

The interview I conducted with this particular chaplain was very rich. As I thanked her and left the hospital, I tried to imagine how it would feel to be at the bedside of a dying person while he is grasping for air and wringing his hand around yours. I envisioned a group of medical personnel in white uniforms, stethoscopes around necks, coming into a room, giving their prescription in milligrams, and leaving the rest for the chaplain, whose job in this case was to witness a man dying while struggling for air. She held his hand for an hour and prayed that he would rest in peace soon and easily. But the emotional experience was extremely difficult. As she was giving witness to a man's pain and suffering, she had to cope with her anger and frustration over a team of medical personnel who were very "clinical" but lacked compassion.

Another full-time chaplain recounts a similar story, which is again an illuminating example of the emotional involvement that chaplains may go through. Fortunately, medical personnel involved in this case had more compassion:

I had a patient who couldn't have dialysis anymore but he didn't want palliation, which was unfortunate because his lungs were filling up with plural fluids and so he was drowning and being in his presence...and I had known this patient for ten years, because I used to work on dialysis.... so I found that extremely hard, so I tried to get some doctors to get him some medication that would dry up the secretions so that he could die in a different fashion than drowning. I went out and I talked to his nurse and I talked with my case

manager and I said like: "why are they giving him something to dry up his secretions right now if he is dying, if he is palliative?" And they finally did get something for him, but in the meantime it was like everybody was taking their time and the doctor was sitting at the desk, at one point, one of the doctors, and I told him what was happening and he said: "yeah, it would be good to talk to the other doctors who were in charge," but he was sitting at the desk and sitting at the desk – you can put it out of your mind and I was sort of aware of that... it was horrible, it really was, and I think, you know, sometimes my frustration in a situation like that turns to anger, you know, so I thought: "God go in that room." I think they thought that that would be perfectly normal, that somebody would die like that and I have seen too many good deaths to think that was normal (Interview No. 7).

In such cases, a chaplain may have to cope not only with a situation in which a patient is about to die in great pain, but also with a group of medical personnel whose sensibilities are not as keen as their professional technical knowledge. The chaplain may experience several emotions simultaneously: sadness for a human being who is suffering, anger over lack of compassion in a medical team and powerlessness over a system whose structure she cannot change. Consequently, a *dynamic of sadness-anger-powerlessness* is produced, making it more difficult to reconcile a medical approach with spiritual care.

In other situations, patients may start complaining about the night-shift nurse or the doctor as soon as they see a chaplain in the morning. Feelings of powerlessness, anger and helplessness are fairly common in such situations as well, especially when unkindness is obvious, but the chaplain is unable to do anything about it. For example, one chaplain described how enraged she was upon hearing an "overloaded" nurse saying: "I feel like I am nursing a corpse" (interview No. 5). Another one talked about a "horrible" situation in which she was seeing a patient and the nurse came in and said to the patient: "I haven't had a chance to get to the bathroom all morning so I sure hope after I am done with you I get a chance to use the bathroom" (interview No. 20). Although they understand that medical personnel are overloaded with work, chaplains

become angry over rude nurses or uncompassionate doctors. On the other side of the coin, however, there are patients who may exaggerate the situation. Consequently, when patients complain about medical staff, there needs to be an informed understanding of the situation. Experienced chaplains tend to approach these situations more wisely than their younger colleagues:

As a young chaplain I remember running down to the nursing station saying that: "do you know that nobody has seen that patient for the last...no doctor has seen that patient for the last two weeks?" They say: "the doctor was there this morning." You see, you know what I am saying, right? So what the patient is telling you is the truth but from their perspective (Interview No. 5).

In such situations, an experienced chaplain does not allow herself to be emotionally manipulated. She instead tries to involve the patient by talking about different ways that they can work together to solve the problem.

It should be noted that as a result of criticism of modern medicine in recent years, several approaches have developed in which the more human aspects of medical practice are emphasized. Chief among them are cultural competence (Carrillo et al., 1999), patient-centered or narrative medicine (Laine and Davidoff, 1996; Charon, 2001), and holistic medicine. These approaches share one similarity in that they focus on elements of human experience that cannot be adequately explained by the biological/mechanical framework for understanding disease. For example, the narrative competence approach as defined by Charon (2001), argues that the effective practice of medicine is no longer supported by a detached concern for patients, but instead requires an ability to acknowledge, absorb, interpret, and act on the stories and plights of each individual patient. The medicine practiced with narrative competence is proposed as a model for humane and effective medical practice. Physicians following this line of medical practice

are encouraged to closely read the literature and embark upon reflective writing in order to examine and illuminate four of medicine's central narrative situations: physician and patient, physician and self, physician and colleagues, and physicians and society. With narrative competence, physicians can reach out and empathize with their patients' illness, recognize their own personal journeys through medicine, acknowledge kinship with and duties toward other healthcare professionals, and initiate consequential discourse with the public about healthcare. By bridging the divisions that separate physicians from patients, themselves, colleagues, and society, narrative medicine offers fresh opportunities for respectful, empathic, and nourishing medical care (Charon, 2001: 1899).

Such approaches are much needed in our contemporary healthcare system. However, until physicians come to understand and appreciate the importance of non-clinical aspect of the human body, chaplains continue to fill the gap, bringing care and compassion to the bedside of vulnerable patients who may otherwise be looked upon as strictly material entities.

Emotional Identification with Situation

In addition to the difficult situations discussed above that stem from not only lack of compassion among clinical personnel, but also the complex nature of some medical situations, chaplains seem to be most challenged when there is a remarkable or striking similarity between the situation and their own personal life. Most chaplains were able to recollect one or two occasions in which they felt most emotionally challenged because the situation was very similar or even identical to their own lived experience. Adopting a symbolic interactionist point of view, we can see how in such situations chaplains

imaginatively take the role of others, identify fully with them, and profoundly feel what they are going through. Female chaplains, for example, may become emotionally affected when a shared sense of motherhood or sisterhood is involved. As one chaplain mentioned, the most difficult cases are the ones that are “too close to home” (interview No. 21). It can be either a suffering patient the same age or status as them, or a family member who reminds them of their own loved ones. Going to visit a young girl who lost her mother in an accident, one chaplain found herself in tears even before the encounter because she envisioned her own daughter, who was the same age as the girl in mourning:

Well, this was years ago when my kids were young, teenagers; I was paged to go to the Emerg in another hospital and it was January. It stormed. There had been a car accident and the mother was driving her 14-year old daughter to school turned a 90 degree turn, slid on the ice into a bus, so the mother... she was killed instantly. We had a 14-year old daughter in the Emerg and that's who I was going to see; so on my way to the Emerg, I started to cry. So I literally stopped, physically stopped, right where I was and said to myself: “Ok, what's going on?” So that is the process of *stopping, going inside* and *saying*...it wasn't this girl in the Emerg that made my cry, I haven't met her yet. It didn't take me long to figure out that I was the dead mother, this was my daughter, emotionally this was my daughter that I was going to see.... (Interview No. 11).

This example illustrates the phenomenological perspective. Through a reflexive process, the chaplain was able to recognize her emotion. By an *inward* process of emotion management (“going inside”) she could get a hold of the situation and prepare herself for her work. The next example indicates how bodily ways of being are central to an emotional experience. Being pregnant, the following chaplain felt such strong maternal feelings that she became almost incapacitated after performing her job:

It was during my second pregnancy and I was the only chaplain in the hospital; I was actually asked to baptise a baby that was dying and so they called me into the resuscitation room because the baby wasn't gonna live for very long. They brought the mother and the father was there, so I did my ritual and was very big pregnant and I had this horrible feeling that: “Oh my god,

this could be me,” so I held it out together and I went to the utility room and began to cry...so that is the only time that I didn’t know if I could do this.... (Interview No. 2).

One chaplain remembers being so touched by a case that she had to leave her work temporarily and go on a retreat in order to process her grief and protect her emotional well-being:

This is quite a few years ago; I had a patient who was the same age as me and she was a twin as I am and I became quite connected to her and her sister.... There were a lot of commonalities, and then when she died they asked if I’d do the funeral and so I did and then I realized I needed to go away; I went to a retreat for a weekend. I didn’t actually know where I was going but I knew I needed to go; when I got there I realized that it was because I needed to grieve, that it was particularly touching for me.... (Interview No. 18).

The following account, in which a chaplain encounters a situation that is similar to her own personal life, bears witness to the emotion management chaplains must perform:

I remember years ago – I am one of three girls – I was in a patient room in another hospital with a family of three girls....my sisters weren’t speaking to each other at that time and the three girls in that hospital situation had a similar dynamic going and their mother was dying and I could just feel the tears coming so I just...I gave some reason, I had to excuse myself for few minutes; I excused myself and went and did that work, *emotional work* for maybe five minutes and I came back to relax, but it caught me off guard. I wasn’t aware of what was going on. I was like: “wow.” It felt like I was in my own family, so I just excused myself for maybe five minutes and I came back and then I could be there for them... (Interview No. 11).

Similarly, another chaplain remembers being very disturbed by the death of a patient whose age and status was quite similar to his. In contrast to the previous examples, this one is rather recent:

We had a young man this past summer who was in his late 30s and diagnosed with cancer and who died three months after his diagnosis and had been with us for quite some time before...he actually died at home but had been with us up to two weeks before he died. I think for me that experience of... when that day came that he was diagnosed with cancer, that was a very emotional day for myself and for the staff and especially when he was told that, you know, they are afraid there is nothing much they can do; they did give him treatment

but it actually did nothing for him, nothing and so I think being with him on that particular day and then being with him after the radiation was over and hearing the doctors saying there is nothing more we can offer at this point and really the treatments we have given you were not successful at all...that was very overwhelming for me. Maybe overwhelm is not the correct word but is was very emotional for me to know that, you know, he had so much hope that the treatments might work, right? And to know that he was a young person, in many ways the triggers for me was that he was young, like he is just a few years younger than I am, he was single like I am single, you know, he didn't have a big family, I don't have a big family, so there were a lot of commonalities and I think for me triggers were on different levels, yes, that particular patient I could connect with him on many different areas.... (Interview No. 13).

If a chaplain has gone through the loss of a loved one, the memories can be revived upon encountering a patient or situation that reminds her of the departed:

My sister died a year ago. When I came back from the funeral like to go back to work, I was called to ICU because of a death. Well, I prayed with that family, my tears came up in my eyes. Because I knew what their pain was....I figured that it was recent loss of my sister... (Interview No. 4).

These examples indicate that chaplains become engaged in role-taking processes by which not only can they imaginatively identify with their patients, but feel the kind of emotions that they experience. This is a symbolic interactionist interpretation of emotions, recognizable in works of sociologists such as Susan Shott (1979), who argues symbolic interactionism is "particularly well suited for the explication of the actor's construction of emotion because its focus is on the actor's definitions and interpretations and on the emergent, constructed character of human behaviour" (1979: 1320).

Apart from emotional identification with the situation, another factor determining the difficulty of the job is chaplains' own emotional stability, which can vary from time to time. According to what is happening in their personal life, chaplains can be subject to unpredictable changes in their emotional well-being. As one chaplain mentioned: "my being overwhelmed is more related to where I am at difficult periods in my personal life,

if there are anniversaries or if I am struggling with something personally” (interview No.

15). Similarly, another chaplain commented on difficult situations in her job:

I don't think I can say it's necessarily the task that makes my job difficult. It's where I am at that is important, it's not external, it's internal: my own sense of groundedness, my own sense of openness, my own sense of acceptance....
(Interview No. 1).

Because their job requires delivery of a service that is emotionally charged, chaplains must take good care of themselves so that they can avoid radical emotional swings. The emotional well-being and daily moods of a chaplain can directly influence her work performance, concentration, attention and ability. I will deal with this issue in the next chapter.

Dealing with Death

One of the main responsibilities of chaplains is to deal with death, to look after dying patients, their families and their emotional responses to death. Normally, chaplains manage to be present at the bedside when a patient is about to die. As one of the most mysterious and frightening aspects of the human condition, death has been a subject of study from different points of view, including the sociological. In one classification, Green and Grant (2008, 278) distinguish four types of death: (1) *Good deaths* as when there is acceptance, awareness, preparation, dignity and effective symptom control, (2) *heroic deaths* as a result of heroic actions, martyrdom or victimization, (3) *social deaths* as when professional and family members cease social contact before actual physical death (e.g. patients suffering from advanced Alzheimer's, brain death, and when some patients in the last stages of their lives totally disengage physically and psychologically),

and (4) *stigmatized deaths* as when either the condition or the actual person is stigmatized – for example, a gay man dying of AIDS.

None of my respondents were specifically challenged by any of these four types of death. However, a new category, *baby deaths*, can be added to the above classification as a separate type to be examined independently.

In her study on grief work among women experiencing perinatal loss, Davidson (2007) realized that caregivers (e.g. nurses, doctors, chaplains, social workers, etc.) engage in a process of sharing and negotiating grief with bereaved women as an act of emotional labour. She identified three intervening strategies (supportive, informational and facilitating) that caregivers use in order to help grieving women cope with their loss. *Supportive* interventions include two types of work: (1) composure work (Strauss, et al, 1997, in Davidson, 2007: 189), such as handholding or touching the brow, soothing sounds of empathy and encouragement, being with women in the middle of the night when they need comfort, and providing space and time for women to spend with their dying or dead babies; and (2) biographical/identity work, such as comparing the baby with its parents (similarities in the face, body, etc.) and drawing generational links. The second category, which is *informational* intervention, includes provision of information through which women can better participate in decision making. Finally, *facilitating* intervention is meant to make the loss real, coordinate the care among different caregivers, help families navigate legal requirements and help them prepare for the future. Teamwork, collaboration and negotiation are essential components of grief work in Davidson's study.

In my study, several chaplains talked about situations involving baby death as the most emotionally challenging cases. It is one of those areas where gender could play a role: only female chaplains talked about baby death as one of the most challenging tasks. It can happen either before or after birth. In any case, it is similar to Davidson's case: a chaplain may find it difficult to manage her own emotions while comforting a bereaved mother. Not only are female chaplains able to identify with pregnant women based on their own experiences, but they can also imaginatively take a motherhood role and experience what women who have lost babies go through. In the case of post-birth deaths, not only is it "unjust and sad to watch all hopes and dreams of a family abruptly gone," but the rituals around dead babies can be disturbing as well:

Often the baby is there in the room and the nurses will dress the baby and wrap the baby and encourage the parents to hold the baby, which is important for their grieving process. I absolutely understand that but I don't like it, I just don't. It isn't comfortable for me... even if a young person dies, it's not as difficult for some as the baby death is; they do irritate me and I know I will do it because it's part of my job and we all take turns but I truly don't like it.... (Interview No. 6).

One chaplain was bothered by the images of dead babies. The body is used as a vehicle to experience unpleasant emotions:

The image of the dead baby bothers me the most; especially there was one baby death, I can't remember why it died but it was all... its skin turned black, you know, purplish black and yeah, I just... it just.... yeah.... it was gross (laughter). I can't think of any other word to explain, yeah, poor baby, doesn't mean that I didn't care for the baby, you know.... (Interview No. 1).

In the case of death before birth, it can be difficult to be with a mother who gives birth to a dead baby:

You attempt to deliver a baby and the delivery is a natural delivery; they wouldn't do a Caesarean section on a dead baby unless there was a really good reason, because there are huge risks involved in the surgery. So these mothers have to actually push the dead baby and that's supposed to be a happy

thing and that is very sad, so they may call one of us... I would come to tell you what I can offer to you while you are here and then the nurse comes in and the doctors come in and the anaesthesia comes in; so probably they finally start giving you a dose of something so that you go into the labour but I probably don't meet you again until the next morning and the baby may have been born in the middle of the night, so I would always go to see the baby before I go back to see the mom if I can, and sometimes they've got deformities, sometimes they don'tusually the nurses dress the baby and if possible one of us might go in with the nurse that is dressing the baby because that is stressful....(Interview No. 2).

Similarly, another chaplain from another hospital says:

When the mother discovers that the child has died in her womb and then the child gets delivered and we offer a kind of prayer or blessing if this is something she and her husband wants, a little ritual where the child is named and blessed and most often that is the most difficult and it's most difficult if the people don't seem to have family or friends or connections.... (Interview No. 20).

For one respondent, the most difficult cases were baby deaths and the death of old veterans, two opposing poles of the life spectrum:

Our Hospital is a veterans hospital and there are often men who fought in World War and they are helpless now and they die; many of them had no family; that is just too much. I feel sometimes, like I feel really very upset with them, but I thought a lot about it: why is it that the most difficult cases for me are babies, you know, the beginning of life and then...the end of life... and it's really because they have no voice, so then I have to be the voice, I feel for them, to speak for them, to talk about them, the parents would do it but sometimes both parents are not there it's only the mother who is there and burden of death for that mother. So I come away and say if I have had one or two traumas I am tired but if I had just one of these cases I am 10 times more exhausted; so it's just inside of me and it kind of takes away my energy.... (Interview No. 9).

As the above accounts explain, working with children and baby death is difficult for some chaplains. A few respondents said they did not choose to work in this area precisely because of the emotional difficulties involved in it. One respondent said: "I can only imagine how hard it is to work with baby death. That sounds devastating" (interview No. 8). Confrontation with pain and suffering is

difficult; it is definitely more disturbing when children or babies are involved. Because of the vulnerable and innocent nature of children, working in the areas of paediatrics and children's healthcare can be very challenging in general. For example, in a study about nursing in a Burn Care Unit, Madjar (1998) realized that no matter how stressful situations are, nurses felt satisfied with their job until the issue of burned children came up. According to Madjar, because children lack the capacity for both self-control and for reasoning in situations that they perceive as painful, the burden of coping is placed fully on nurses (in contrast to an adult's situation where it can be shared). Consequently, children's uninhibited responses to painful procedures were the main source of stress for nurses working in the Unit, making them feel *tense, dissatisfied* with the day's work, and drawn further into the patient's experience than they would have preferred (Madjar, 1998: 123). Also, nurses' perception of pain, as experienced in the body, was changed after they saw and dealt with it in children's bodies.

Inability to Create Effective Communication and Relationships

A source of difficulty may come from a chaplain's sense of inability to connect with patients and encourage them to open up and talk about their problems. Earlier it was argued that one of the most important tasks in hospital chaplaincy is to create effective communication so that a contextual spirituality can be developed, helping patients gain access to their inner sources of strength. When there is no sign of progress in a relationship, a chaplain may feel frustrated:

I find it emotionally challenging to work with people who are very shut down emotionally, because a lot of times people would come into the hospital and

they become the objects of other people's work and so people shut down, and to coax them up into feeling their own feelings and having their own....to regain some autonomy on occasion can be very frustrating (interview No. 8).

Similarly, another chaplain describes her most difficult cases as:

Listening to folks that simply want to talk but they don't actually say anything; so they are not actually expressing any emotions or feelings. For me that's emotionally challenging....it's emotionally challenging to keep myself present and, or to stop myself from going, you know: "Ok, what are you hanging on about?" I don't get irritated with them...but I can be as patient as the whole day with somebody who wants to really express what is going on; but with folks who take ages and ages to say a huge massive long story that I can't see what it's got to do with anything at all, it's emotionally challenging for me personally...

Interviewer: What kind of feelings might you experience in such situations?

Chaplain: Frustration, annoyance, sadness that this person...that all they can tell is decorating their house...so those are frustrating. However, what I need to do is to say to myself – and I literally have to talk to myself – that: "perhaps decorating their house is important?" "Perhaps they are mourning not being there?" So if that question occurs to me, I will refocus on what it is they are feeling rather than the actual outfits of the story; so I would actually ask them "are you missing your home?" because technically if people are saying something there is a reason – they just don't know how to get to what the reason is. So that's challenging for me to actually take the time to work through that.... (Interview No. 3).

Such a sense of frustration, annoyance and sadness can be of course mutual, when both chaplains and patients see a lack of success in creating productive communication. However, chaplains are specifically challenged because it is their job to initiate an interaction competently and direct conversations towards the development of contextual spirituality. When family members or needful patients dismiss their service and see no value in the kind of support they can potentially provide, chaplains feel powerless and incompetent. Speaking in Garfinkel's language, such situations can be described as an ethnomethodological breach where one is unable to sustain the reality of the encounter as an "ongoing accomplishment." Chaplains do not expect every client seek their help

desperately, but since their job is “to be with people when they are in pain,” some chaplains find it very difficult to watch uncooperative people suffering from pain for which they could have provided support. One respondent described herself as a “people helper,” and a “people pleaser” (interview No. 12), who cannot see suffering without doing something about it.

Creating and maintaining balanced relationships with patients is essential. For chaplains working with cancer patients, it can be challenging to maintain balanced, emotionally stable relationships in the long-term, whereas chaplains who work in critical units may complain about the passing nature of their relationships, which prevent them from developing proper emotional bonds with a sense of continuity. In the first group, chaplains may encounter patients who are too demanding and think “you have no one else to see but them” (interview No. 13). In the second group, chaplains are afraid to become involved with patients in such a way that is “just kind of touching the surface and try[ing] to hold them back” (interview No. 14).

For the only Muslim chaplain in the sample, who had several years of experience with mentally ill patients, maintaining balanced relationships can be exceptionally hard. As we talked extensively, it turned out that being a chaplain in a mental health and addiction facility brings extra difficulty because in a general hospital, one deals with people who are struggling with concrete realities of all kinds, but in a mental health and addiction institution, one has to deal with individuals who are struggling with reality and unreality, namely, delusions. Consequently, creating constructive relationships and effective communication with mentally ill patients can be very tricky. Patients expect the chaplain to join them in whatever feelings they have. However, the chaplain has to:

Monitor emotional response to someone that might be hallucinating, or suffering with delusions, and asking you to join them in something that is completely unreal....So that emotional response is not to be impacted by the words, because you know that the words are not real: this person is not such and such or the TV isn't really talking to them or FBI or CIA is not acting on them, so to monitor that where you do not respond but yet you are present to the person and you are listening. So that kind of monitoring, that emotional response to a non-existence stimulus....that is challenging, that is very, very challenging....

Interviewer: Because you don't want to look as if you don't care for that person.....?

Chaplain: And you don't want to reinforce the delusion that they have (Interview No. 10).

Working in a mental health center as a non-white person, the same chaplain remembers how angry he once became after being called a name. Anger management seems to be a key issue for chaplains working with vulnerable and marginalized populations:

I remember one day I was going outside and I was behind someone [client of a mental health center]. So he turned around and said: "don't you follow me nigger." So he used an n word. I was like "wow, I am not used to being called this name for many years." So your response is anger, right? "Who you calling nigger, huh?" So I said to him, you know, something and to monitor an anger response in a respectful and informative manner was difficult. So I said to him, you know, "we don't use those kind of terms in the center, we respect each other regardless of who they are." He says: "I don't care about any....just don't follow me." The following day the same guy saw me and said to me: "excuse me, yesterday I was angry. I apologize for what I did," because I think in the moment he was angry at something or the other and really he needed respect or space and there wasn't very.... so he turned around and saw me and....but the following day when he kind of realized that...I don't know if it's for the words or saying "listen, we don't use these words here, we respect people, we don't call names," maybe that might have been....or he might have been cooled down and kind of figure out that what he was angry about wasn't there anymore. So he was able to apologize, but monitoring an anger response to a client is sometimes difficult.... (Interview No. 10).

To sum up the argument of this section, a chaplain's goal is to interact with people in order to establish contextual spirituality and provide spiritual care. A negative

evaluation of self may occur if chaplains fail to make that connection and create a productive relationship. Following the Weberian tradition, sociologists of stress have shown how the inability to achieve important goals is related to poor mental health (Idler, 1987; Simon, 1997, in Horwits, 2007). As Carr (1997, in Horwitz, 2007) argues, adults who do not attain goals they set for themselves report more distress than those whose attainments match their original aspirations. From this analysis, it can be argued that if chaplains feel unsuccessful in accomplishing their goals, one of which is to build productive relationships with patients, their mental health will be affected negatively.

Emotional Dissonance

A few respondents in this study had difficulty in convincing other healthcare providers of the importance of spiritual care in successful treatment. Although I did not ask about satisfaction with salary and financial aspect of the job, a few chaplains believed, at times, their institution or other healthcare colleagues do not recognize, acknowledge or appreciate the significance and value of their work. For example, one chaplain believed: "if people are expected to be able to lean on me, I also need to be able to lean on something else" (interview No. 15). In her view, there needs to be a sense of *institutional support* in order to provide high quality care. Another chaplain complained that "when there is a budget cut we are one of those soft services that are very vulnerable and sort of have to defend our role." This, she believed, has put chaplaincy in a "tentative, very precarious position" (interview No. 6). One respondent, in particular, was unhappy with medical personnel who are unable to see the depth of emotional involvement in which she engages:

Sometimes the staff that I work with, they have their own ideas of who I am supposed to be and what I am supposed to do....they don't understand what it means to go from room to room to room and be happy, distraught, happy, crying.... and have them [patients] telling stories that are very distressing.... the spiritual care staff that I work with, they understand that but some of the nurses and the nurse managers they don't, you know, they don't understand that perhaps as a human being I can't sit face-to-face with people seven and half hours a day and...

Interviewer: Be in that intense exchange of emotions.....?

Chaplain: Yeah, I mean I can have two deaths in one of my units and then I go to the next unit and I can't go and tell everybody what I have just experienced and they are looking at me like: "where have you been all day?" You know, I am taking care of the business but I can't tell you about it. If there was a very difficult death, I can't go and tell people about that; it's none of their business but....I need to go and take care of myself and then come back and provide care for the patients and the staff but there is not a lot of education for other professionals, I mean some of them recognize it, some of them see it and say: "Wow, you've got a hard job," because they see me in there and they know that everybody else has left except me and the family and I am there.... (Interview No. 15).

As this example illustrates, chaplains may be expected to live up to the expectation that they should always be present and emotionally prepared to give support ("where have you been all day?"). In the real world, however, it is simply impossible to "sit face-to-face with people seven and half hours a day." As a result, chaplains may find themselves in a situation where they are confronted with conflicting feeling rules: those coming from the medical system and those coming from their own ideas about job performance and emotional involvement. Emotional dissonance happens as a result of exposure to conflicting feeling rules that make it difficult, if not impossible, to obtain a "correct emotional climate."

As another example, several respondents said that whenever conflict is involved, they feel most emotionally challenged. This was particularly remarkable among those chaplains with managerial positions in addition to clinical work. As already discussed,

sometimes these chaplains have to deal with a system whose budget is limited yet demands high quality care. Therefore, they may encounter conflicting feeling rules as to how they should behave and present themselves. For example, one chaplain who was co-manager of her department found it difficult to criticize her staff when their performance was not satisfactory because to be critical can be interpreted as “uncaring and inattentive” (interview No. 4). For another respondent, it was difficult to express anger even when it was legitimate because the expectation is that, both as a woman and a chaplain, she should not get angry. Here gendered feeling rules could be also added to the situation, making it even more difficult to avoid emotional dissonance. Likewise, chaplains may find themselves in tricky situations in which, on the one hand, they are expected to be involved so deeply that they can genuinely understand the depth of pain a person is suffering, sympathizing with them fully and compassionately; on the other hand, they need to maintain a certain distance so that as professionals they will be able to perform their jobs and avoid being overwhelmed by particular situations. There should be, therefore, a balance between emotional attachment and detachment, and a stable emotional climate. This is illustrated in the words of one respondent who commented: “it is that challenge to be emotionally open to people without having your own stuff intrude on it that makes you a good chaplain” (interview No. 11).

The above situations are similar to what Whittier (2001; in Kenney, 2010: 115) describes as “oppositional emotions.” Studying adult victims of child abuse, Whittier realized that whenever there is conflict between therapy and action, conflicting emotions can be generated when attempts to politically empower victims are undermined by media presentations of victims as damaged and pitiful. When chaplains are expected to behave

according to certain feeling rules – which are not necessarily reflexive of the realities of the job – conflicting or oppositional emotions may arise that intensify emotional dissonance.

Throughout this and the previous chapters, I have been describing what it means to be a chaplain from an emotional perspective – typical work situations in which chaplains may find themselves emotional and different types of experiences they may have as a result. In other words, I have tried to draw an *emotional map* to describe the emotional experiences of chaplains. I then pinpointed *emotional hotspots*, namely, points where chaplains are likely to become challenged, if not overwhelmed, with job difficulties. In the following chapter, I will discuss the resources and different supportive systems on which chaplains rely in order to cope with these emotional difficulties. What different strategies or techniques are involved in emotion management? How do chaplains avoid burnout, fatigue or other occupational risks? What are the rewarding aspects of the job that keep chaplains going? And what are the resources on which chaplains rely to balance their work and life? These are the types of questions that will be dealt with in the next chapter.

Chapter Six

Emotion Management in Hospital Chaplaincy

Interviewer: And what kind of other practices, apart from prayer, do you do to protect your emotional well-being and mental health?

Chaplain: Sometimes I buy myself a rose; sometimes I just stand under the shower and let those little bits be cleaned off me. I imagine them washing down the drain with water....

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Physical Contact

Throughout the research, I was curious to understand how frequently chaplains make physical contact (e.g. hug, hold hands, pat shoulders, etc.) and what role such contact could play in managing emotions. I was also interested in whether there is any feeling rule with regard to such contacts that tells chaplains how they should approach people. Although a study based on participant observation can better answer this question, in most interviews I asked about physical contact, and except in few cases, most chaplains said they would prefer to have as little of it as possible. It was at odds with my preconception of physical contact as a powerful means of establishing intimacy and facilitating emotional expression. Occasionally and with some people, chaplains may exchange hugs, especially if they spend a considerable amount of time together and develop emotional bonds. Holding a hand or touching a shoulder is much more common. However, to avoid complications, potential problems or misunderstandings, most

chaplains tend to be very cautious of physical contact and rarely initiate it. As one respondent, not exactly in support of physical contact, remembers:

Just yesterday a lovely woman Muslim lady, she wanted a hug. As we got into the hug I realized I was over hugging; she just wanted to do a formal embrace and a kiss, you know, so I remember walking to work this morning and I said: "remember to let them lead, they needed to do what they want, not me"I didn't want to hug at all, but I did what I thought was right, you know, so I try to be aware of that; I am pretty aware of body stuff like that and I would rarely, rarely, rarely initiate a hug (interview No. 5).

A similar example from another chaplain:

I wouldn't be doing that if it was a man. I had a wonderful teacher many years ago, a Muslim couple that used to visit all the hospitals and I was working at another hospital at the time and they were new and I was new and I gave Muhammad a hug and he asked if he could speak with me so he came to my office and said, you know, he really enjoyed my company and he was really grateful that we were such good friends but in his tradition that wasn't appropriate for him. So I apologized and he said I didn't need to because I didn't know at the time and the joke after that was always I would give his wife two hugs so she was to take one home for him (laughter).... (Interview No. 12).

One chaplain expressed her concern with physical contact as follows:

You have to be very careful. I found that it's better to do [hug] when someone else is there with you rather than doing it alone because you get into trouble if you do it just alone. Because then you could be accused of something. It is something that I am very careful about. But if I feel the person needs a hug I am not gonna say no..... (Interview No. 4).

Deciding to initiate a hug or not can be a matter of emotion management. One respondent believed that while initiating physical contact, chaplains must be aware of their own motives: is it the chaplain who needs the hug or the patient? In interaction with patients, chaplains must be self-conscious about their emotional triggers:

So they [patients] must initiate the touching or if we feel we want to reach out we must sort of mentally ask ourselves the question: "who needs the touching here, me or the patient?" So if I can answer that question with certainty and discernment that I can't touch, then the outcome is that I might reach for their hand or put my hand on the shoulder, but that's....I don't usually do that.

That's very rare. Maybe if it's a child or if someone just kind of collapses in tears into my shoulder then of course the touching is there and I circle them with my arms.... (Interview No. 6).

Physical boundaries are important here. As the above example explains, it is through physical contact that the intensity of the emotion experienced is determined. Moreover, physical contact also influences the type of emotions experienced according to gender and sexuality: female chaplains are more willing to exchange hugs with women than with men. Male chaplains tend to be more reluctant to have physical contact in general, no matter what the gender is. Both Muslim and Jewish chaplains specifically mentioned that hugging a person of the opposite sex could be inappropriate and uncomfortable. In any case, chaplains are not usually initiators of physical contact. Their professional training encourages them to avoid physical contact. There are cultural and religious norms dictating how one should approach physical contact. As a female chaplain says:

It depends on, it really depends on, I guess, how physically close I am to them and what their cultural background is. I mean I have been with families where they were orthodox Jews and if it's the man I am not touching them because, you know,.... or observing Muslims; so you have to be aware of the *clues* that people are giving you in terms of physical contact. I mean if it is some little lady who needs a hug, sure..... (Interview No. 2).

As the above examples explain, there are certain expectations with regard to physical contact. "The clues that people are giving" are in fact cultural norms and feeling rules around physical contact. They illustrate the importance of non-verbal communication in chaplains-clients relationships. Here, too, chaplains need to be competent in realizing how far they should go in an interaction to have physical contact.

Crying as an Emotional Expression

Among different emotional expressions, I was interested in crying for two reasons: (1) to see if there is a feeling rule with regard to crying, telling chaplains how they should express emotions, and (2) to see how deeply chaplains are touched by work situations, to the extent that they may actually be reduced to tears. Like the physical contact question, in most interviews I asked specifically if chaplains can remember the last time they cried and the reason behind it. I was able to gather data on both issues. It was in response to this question that chaplains began to tell fascinating stories about difficult situations and challenging experiences. As I expected, most chaplains said they do not cry frequently in front of others. A few said they hardly cry in their personal life. However, most respondents were able to distinguish between “having teary eyes” or “shedding a few tears” and “sobbing.” The difference between the two provides an example of how feeling rules define emotional display. Sobbing is never acceptable, but shedding a few tears is normal as long as the emotion behind it is naturally felt. One can imagine a *crying continuum* with “absolutely no tears” at one extreme and “bursting into tears” or sobbing at the other, and “misty eyes” in between. Chaplains can be placed at different points of the continuum according to both their experience of crying and what they think about it. Once in a while, some chaplains find themselves in the middle ground, where their eyes become tearful and a few tears roll down their cheeks. However, bursting into tears or sobbing loudly is a rare occurrence that hardly happens in the workplace according to my respondents.

Crying can happen either backstage (e.g. the chaplain’s office) or on the front stage, namely, with patients and their families. When it comes to the front stage, a few

chaplains believed any kind of crying can be unprofessional, and incompatible with the image they would like to convey as care providers. Consequently, not only do they not cry in front of patients, but they dismiss any form of crying coming from other professionals as well. For these respondents, crying is not compatible with the “personal front” (Goffman, 1959) they wish to establish before performing their role. As Goffman argues, a part of personal front includes looks, posture, speech, patterns, facial expressions, bodily gestures and the like. One chaplain said:

I actually feel when I am entering a room I am the *strong* one, you know....because I have been with chaplains who do that [crying] and I often thought: “Oh, please don’t ever do that when you visit me” (Interview No. 3).

Similarly, another chaplain:

I barely cry....I do see social workers, I have even seen doctors crying with them [patients] but I rarely do; I wouldn’t like to cry, I can be very touched by it, though....it just wouldn’t be my way...I barely cry in my personal life too (Interview No. 5).

One chaplain believed crying in front of patients could send a wrong image:

If you cry with people then they want to comfort you and then they feel like: “this is too much for you,” like “we are giving you pain,” “we are providing pain for you,” but I’d like to see it like: “I’ll be with you in the pain and I hold you” (Interview No. 20).

The desired image is not necessarily one of a strong person who does not get affected by emotions. It can be, as one chaplain said, an image of peace: “The image I look at is an image of peace. If you start to cry, it’s a little hard to see that peace” (interview No. 4). As this example indicates, not only could crying be incompatible with “appearance” on the personal stage, but also with its “manner,” namely, those stimuli which function to warn us of the interaction role the performer will expect to play in the coming situation (Goffman, 1959: 24).

One chaplain was attentive to the feeling rules around crying. Therefore, she manages her emotions according to the requirements of the situation. Although she feels an urge to cry, this chaplain suppresses her tears in order to concentrate on her job:

When I am going to cry, it's when I am with the [dead] babies and when I am praying with the family. And in prayer we try to be a little bit more formal than we would be in conversation, so I probably may snuffle during it but I am trying to give these people the experience of a ritual, so I probably try to tie that up for me.... if I am doing something formal I want to keep an eye on that.... (Interview No. 2).

One respondent provided an interesting reason as to why she never cries in front of patients. Even though she believes crying is good, she is unable to shed tears with patients:

My dad was Italian and they are very emotional; my mother was Irish-German and they are very unemotional (laughter), and my mother, I think, always set up this thing, you know, that "weak people cry" or "people who are selfish cry," so I think I learnt how to switch it off, which isn't a good thing because I think I can get physically sick...

Interviewer: So you suppress your feelings in this case? You want to cry but you intentionally....?

Chaplain: I don't even have to do it intentionally anymore, because it's so learned behaviour ...I don't even...it's awful now...now I see it as a drawback... (Interview No. 7).

In contrast to the above examples, another group of chaplains believed crying, both on the back and front stage, is beneficial. In the case of backstage crying, it can have a cathartic effect: "when situations are pathetically sad, I always feel better after a good cry" (interview No. 2). Such a release of tears does not usually happen in front of patients, as it may be in conflict with the chaplain's professional role and expectations

about their role. Chaplains may go to their office, the utility room or as the following account suggests:

Normally, I don't cry when I am in the middle of a situation, when I am doing my job, when I am in the presence of patients. That's not when it happens, I may go down to the chapel and there the sadness might come up.... (Interview No. 16).

In terms of front stage crying, a few respondents believed it is actually a sign of care and commitment to the relationship, indicating how deeply a chaplain feels for patients. As the Jewish chaplain recalls:

Early in my career I was training in the palliative care and I met a family and the patient was a very young woman and dying obviously and I couldn't help myself...I wasn't crying in a very hysterical kind of way but tears were just coming and I couldn't help myself and I said: "I am so sorry that I really feel so deeply for you that the tears are coming out." She said to me: "thank you for caring enough to shed a tear," and from that moment I realized, you know, that we are people, too, and if it happens that way...whatever the situation is such that you are emotionally involved, usually it helps, usually I have not get experience....nobody ever actually said to me "why are you crying?" "You are supposed to be here for me." Usually it is interpreted as: "I see that you care deeply about us" and usually it's well accepted.... (Interview No. 21).

Likewise, another chaplain working with abused women believes:

If it [tear] is a natural response to the patient's situation, you know, naturally evoked because of the relationship that we have and the caring and sharing, then I feel it can be very appropriate to show it; the client can experience that as an affirmation of our connection.... (Interview No. 19).

Another respondent used an analogy to explain the importance of expressing tears as a breakthrough in a chaplain's relationship with patients: "there is a difference between showing somebody your scar and saying, you know, 'I have had a tough experience'" (interview No. 15). What she was trying to say is that by seeing tears, patients come to appreciate the care and commitment that the chaplain is ready to give.

One chaplain believed that not only is crying in front of patient not bad or unprofessional, but:

I wouldn't be human if I didn't cry. Certainly in perinatal cases or great tragedies, lots of times I have stood at the bedside and when my job is done we are all standing there in silence and the tears are right there on the surface (Interview No. 16).

In spite of different attitudes with regard to moderate forms of crying, all respondents seemed to be in agreement that extreme forms of crying are both unprofessional and inappropriate. None of them were actually able to remember an occasion in which they sobbed hysterically. At worse, they had to excuse themselves and leave the situation momentarily in order to regain composure. Here most chaplains seemed to follow a feeling rule telling them how they should appear with regard to crying. No one accepts a chaplain who is emotionally overwhelmed and is carried away with tears. Several chaplains used the word "inappropriate" to describe such a situation. A very clear feeling rule prevents them from expressing emotions in extreme ways. In a funny analogy, one respondent said:

You know the expectation; it's there, and, you know, people can think: "Oh my God, the Captain of the ship is panicking; we are in a bad shape now." So that's part of it, the role has this expectations of strength, of the ability to contain emotion, of monitoring your emotions, to show the emotions appropriate, to express emotions appropriately, that's there, you know, conducting memorial services, you have the same thing, particularly when you go to a memorial service where you know the client.... (Interview No. 10).

Likewise, another responded believed:

If I am getting too emotional then I am just one more patient, right? Because I need to be there...like if you are a lifeguard, right? If you're gonna be pulled under and drowned that's not good, you need to have some kind of stability there so that you can help them.... (Interview No. 8).

Another respondent felt similarly about sobbing:

If I were sobbing then I have lost my professionalism, and then they turn caring for me instead of me caring for them – so sobbing no, not in front of a patient or family member, not ever; teary, yes, and I see a difference between those two and I often talk with staff members as well who are teary and that's ok and that is being human. There are things that touché me and I have relationships with some of these people and it's sad, and if I have a tissue and I am dabbing a couple of tears that's ok, I mean, I have worked with many staff people who are in that place and that's what it is to be human (Interview No. 15).

As the above examples indicate, attitudes toward crying/not crying are different.

Speaking from a dramaturgical perspective, one can see great potential in using tears as a *strategic signal* for interpersonal emotion management. It can be tactically used to perform emotion management on others. As the Jewish chaplain explained, having tears in one's eyes conveys the message that one actually cares for the patient and is moved by their pain. Similarly, extreme tearfulness (e.g. sobbing) conveys a negative and inappropriate image with which no chaplain wishes to be identified, since it signals incompetency and unprofessionalism. A more subtle understanding of crying could possibly be obtained by participant observation, but as explained in Chapter Three, this research method was not utilized in my study.

Work-Life Balance: Emotional Separation

All chaplains who participated in this study were able to identify several sources of support they can benefit from at different points, separately or together, in order to protect their health. There are also various techniques of emotion management and methods of self-care that enable them to avoid or mitigate occupational risks. I will start with emotion management techniques.

In order to maintain a work-life balance, chaplains consciously manage to separate work from other aspects of their lives. Like other professionals, they seek to obtain some degree of objectivity in order to put concrete boundaries between work responsibilities and personal life. Interestingly enough, several chaplains described specific rituals as strategies they use in order to separate the work environment from home life.

My symbolic thing, everyday, is to transfer my pager to the person who is on-call and knowing that that's it: I am no longer responsible for anybody here at the end of the day, you know; I would pick it up tomorrow. It's my way of...work is over. It's almost like an *emotional break* from the place; just transferring my pager to the person who is on-call and to say: "it's all yours now" (laughter) (Interview No. 13).

As a cognitive method of emotion work (Hochschild, 1979), the following chaplain manages to perform her job as effectively as she can and leave the rest in "God's hands":

My attitude is when I am here I am gonna do the best job that I know how and when I leave, I leave it in God's hands and so I don't have to worry about people not being well afterwards, because I know God is gonna look after them. I am not God, God is always gonna be here so I can go at the end of day, you know, knowing that I leave them in good hands and the rest will be still here when I come back. A friend of mine always says: "why did God make tomorrow?" So we can come back and pick up what we left off (Interview No. 12).

Similarly, another chaplain talks about his daily practice to separate the hospital and home environments:

I walk to work. It takes me a half hour to walk to work and then a half hour to walk home, and for me the process of coming here...because I am not rushing with the subway or driving....I don't have to pay a lot of attention to my route... I am just walking...preparing myself emotionally to come into this environment and be spiritual care provider here and on the trip to home to divest myself of that, sort of free myself of the experience of being here which is very much...the normal feelings in the hospital are sense of ambiguity, of not knowing, of fear, of anxiety, and to sort of divest myself of that on my walk back home, I think is a really important part of my personal process. It's a walking meditation... (Interview No. 8).

Likewise, another chaplain says:

One of the methods that I use when I come to work I step into my work place with my left foot and pray, and when I leave I step out with my right foot and pray. This has helped me tremendously; it actually separates my work life from my outside life. So I am....I know that I am doing physical action that consciously reminds me of where I am. I am at work and at this situation – this is my role.... (Interview No. 10).

Similarly, another chaplain explains:

I try to consciously wash my hands before I go in as a way of preparing myself for when I walk into the space, and then when I leave, the washing of my hands is also a way of leaving it behind so that I don't carry it home... (Interview No. 14).

Such idiosyncratic practices can be described as *ritualistic* methods of emotion work, an addition to the three methods (cognitive, bodily and expressive) that Hochschild (1979) introduced. Since chaplains perform these rituals on a daily basis, they can be also described as *daily rites of passage*. Studied frequently by anthropologists, a rite of passage is a ritual that shows what social hierarchies, values and beliefs are important in specific cultures. Rites of passage are often ceremonies surrounding important events such as puberty, coming of age, marriage and death (Bell, 2003). Since practices discussed here are personal, contextual, and idiosyncratic, they can be described as *micro, daily, rites of passage* used to manage emotions.

By using such rituals, chaplains unconsciously separate their work from other areas of life, keeping in mind that what happens in the hospital should not be seen as their personal pain, problem or hardship. Although once in a while it may become difficult to get over a particular case, in most cases chaplains are able to move forward and put their work-related thoughts behind them. They should be able to separate other people's pain and suffering from their own or they fail to survive in this job. As one chaplain said:

I join them [patients] and travel with them but in the same token there is a certain amount of professional distance that I have because at the end of the day this isn't my family, this isn't my best friend; we go our separate ways at the end of our time together and I don't miss these people at birthdays and family gatherings (Interview No. 15).

The following account describes how carefully a chaplain separates her work from her personal life so that the boundaries of each sphere remain intact:

I try to make a point of leaving on time at five o'clock. It would be very easy to think: "well, no I want to finish the charting;" "well, I don't want to leave that till tomorrow," you know, you could easily.... or "I want to go back one more time to see...." It's a discipline; it's also a recognition of boundaries, like this is work (Interview No. 20).

As another part of maintaining work-life balance, chaplains may decide to work part-time or change their church so that they do not have to commute long distances. In two particular cases, one chaplain decided to work part time to avoid driving long distance on a daily basis from home to work and vice versa:

I used to work full-time for a contract position on oncology and palliative care, so I know what the burnout rate at this profession is, but I learned pretty quickly that with the pace I was going: working full-time and commuting...I have a long commute that did not give me enough solitude to recharge and to have that balance, so I chose to work half-time so that I can still have a family life, my professional life and some time for me to recharge... that's very intentional; I couldn't do that and even now sometimes I struggle because there are many demands and it can be hard to balance everything (Interview No. 15).

Similarly, another chaplain decided to change her church because of the inconvenience of commuting:

I was with one church for 22 years and I moved when I got this job because...the stress of the commute was too much. I recognized that so I said: "I can't do this job and live in the stress of the commute too." When I see stress in my life I get rid of it if I possibly can, so I did; I got rid of that stress and so I just joined a new church (Interview No. 16).

Hospital chaplaincy is very reflexive work. Chaplains must be very familiar with their own emotional reactions to different situations. The importance of residency programs lies in helping chaplains explore their emotional world in deep and profound ways so that later on when they are in serious work situations, chaplains know how to deal with their own as well as others' emotions. After all, successful emotion management is only possible when a chaplain knows what her limitations and triggers are. This is a point stressed by several respondents. One experienced chaplain talked about *brownout* as an indicator that comes before burnout:

We have to watch for brownout, and brownout is when you are in a city and the lights dim but they don't completely go out and then sometime later they do, and sometimes later they come back on, so that's what I monitor myself for all the time: brownout. If I feel getting dim, then I take measures... (Interview No. 12).

One chaplain said she misses her student time because they had to prepare critical incident reports, talking about and describing their own feelings in work situations. Such reports are very helpful in enabling chaplains to understand the emotional consequences of the job. In a remarkable example, another chaplain says:

I think it's important for us as chaplains to reflect on our feelings and we don't always do that. The example I would give is of a situation where a young woman died and I got to know her family and her very well and she was not willing to die; I mean she was a teenager. I was so busy helping her family that I didn't realize what it was doing to me and then I went on retreat. I think two years later – two years it had gone by – and the retreat leader talked about a situation where somebody had died from an operation on their stomach and what a needless death it was. I went back to my room and I cried and I said: "what am I crying for?" and I realized that I was crying for that 19 year old who died two years before and I didn't realize how deep that pain went (Interview No. 4).

In their professional training, chaplains are vigilant about identifying and naming their own emotions so that they can effectively manage them. The chaplain who was

called to visit a girl in mourning the same age as her own daughter explained this process as *encounter transference*:

By encounter transference I actually realize who I am to that person that I am going to see; who was that person to me? She was my daughter emotionally; so I just stopped and said to myself: "What's going on?" "Okay, this isn't my daughter, this is whoever, okay?" This is transference; once I understood what was going on, I could go and – it just took a second or two, you know, it happens very fast – I could go and be with her *appropriately*. It's ok to get teary, to shed a tear but if I haven't done that work on my way to the Emerg, I might have been *inappropriate*; I might have just sat and cried with her, which is not very helpful. But I could go and be a chaplain to her, be there for her instead of being lost in my own grief....if you can't do that kind of self-awareness piece you're gonna be destroyed by the emotions; I would be destroyed, because you are always in difficult situations. So this is an example of where my training helped me, walking there protecting myself, because if you don't.... if you are not aware of that transference, which is happening in every interaction, it destroys you... (Interview No. 11).

The above example explains how chaplains manage their emotions according to the feeling rules of their job. Similar to Hochschild's discussion, I was able to find examples in which chaplains work on their emotions in order to make them appropriate for the situation. For example, there are situations where chaplains feel angry over medical personnel but suppress or try to transform their feelings into something milder. Mindful of the potential harms such emotions may bring, chaplains remind themselves to let them go. Like Hochschild's flight attendants, chaplains may actually talk themselves into changing a feeling or recognizing it as something different. For example, one respondent described a mental mechanism she benefits from whenever emotions are high in a situation:

I have a natural, for better or worse, shut down mechanism (laughter), you might have been hearing about this from other folks as well; so I am monitoring what I do – it's like watching my feelings, you know: "Amélie, what's happening with you?" and then if...it can...it might even happen not as a conscious choice, there were times when it didn't, it wasn't a conscious choice, there would be a process of numbing out those feelings and becoming

very heady, so my rational mind would take over: "Amélie, what do you need to do to manage the situation?" So my rational mind would say [to my emotional mind] like: "you sit in the back, I am taking over here;" and, you know, it would be all about what needs to be done (interview No. 19).

Another chaplain talks about the same mechanism in different words:

The measure that I am talking about is my dream life, when I dream about my work place. It is my measure that says you are working too hard or your work is impacting too much on your inner life and you need to do something about it, right? So that dream life is my measure, it's my yardstick, and fortunately, thank goodness, thank God, I haven't dreamed a lot about my work, you know, in my life; and I become very alarmed when this happens, like: "How I am doing in my work?" "What was happening here?" So I try to change things, or I try to do things differently, or I try to address a pressing problem (Interview No. 10).

Such self-talks or self-reminders are psychological methods of emotion management that chaplains use whenever they find themselves in a stressful or crisis situation. They can be explained by Denzin's (1985; 1984; 1983) phenomenological approach in which emotions are seen as products of the social interplay between inter and intra personal interactions (1984:54-57). According to Denzin, our emotionality is influenced by inhibited social acts, subvocal thought, interpretations and self-conversations in social action.

Chaplains need to be able to understand their own emotions first and then try to help others. Hence, it is important to be self-reflective so that they can fully evaluate their emotional reactions and be prepared to act on them. Interestingly enough, after a while, chaplains become experienced and learn where their triggers are exactly located and which situations are more likely than others to touch them emotionally. They can avoid extreme emotional reactions by learning about their limitations and sensitivities. Residency programs are important, in that they enable chaplains to draw their own emotional map and pinpoint their emotional hotspots.

Methods of Self-Care: Physical, Spiritual and Emotional Well-being

In addition to the psychological mechanisms, practical decisions and specific rituals discussed above, chaplains need to be extremely attentive to their self-care and well-being so that they can maintain a high level of health. Participants of this study were able to articulate a variety of different methods of self-care and strategies to cope with emotional difficulties. All respondents showed a heightened level of attentiveness to their spiritual life and emotional well-being. Prayer, meditation, reflection, listening to music, exercise, balanced diet, sufficient sleep, participation in life-giving activities, socializing with friends, community work, silent retreats, vacation trips, professional training, and educational workshops are the typical means through which chaplains maintain the well-being needed to perform their job. They can use a combination of different mechanisms at the same time or, depending on the situation, one particular method may be given priority over the others. When it comes to self-care, taking good physical care of oneself is extremely important. As already discussed, this job requires full commitment and full emotional presence. Consequently, chaplains must be attentive to their own needs so that they can perform well on the job. Speaking from a holistic perspective, one chaplain said that in order to be emotionally stable, her physical needs must be met first:

Usually I have an intense day and often I go to the gym and I work out; I am very...I eat really well, I take very good care of my diet and try balance it so I don't eat processed food or a lot of processed food...I am very careful about that....I make sure that I get a good sleep; I meditate on a daily basis... so those are the sort of the things that I do.... (Interview No. 6).

I realized that the spiritual life of chaplains is very important to give them a sense of orientation and groundedness. Spiritual life can be enriched through, among other things, prayer and meditation. For several chaplains, prayer was an indispensable part of their

daily work. One chaplain said: "I do pray and ask for God's guidance and wisdom before I go to a situation" (interview No. 9). For the only Muslim chaplain in the sample, it was important to maintain his Salat, Muslim daily prayers, which have to be observed five times a day. Another chaplain said:

I pray every day. By giving the situation to the lord, praying that I would have the strength to go back to the next room and be as compassionate with the next person as I was with the first person. That is why my prayer list is so long, because I pray for a lot of people and I still feel that they are in larger hands than mine... (Interview No. 17).

"Giving the situation to the lord" is a cognitive technique of emotion management. Coupled with prayer as a ritualistic technique, it helps this chaplain perform her job. Some chaplains distinguished between prayer and meditation. Even though several chaplains said they meditate regularly and separated this from prayer, I found meditation to be specifically significant in the words of the two Buddhist chaplains, whose religiosity is more embedded in meditative practices. One of the Buddhist chaplains talked about several meditation practices she benefits from, including yoga and *mindfulness meditation*: a program created by a molecular biologist, John Kabat-Zinn, who has combined elements of the Buddhist tradition with health care. The program is called MBSR: Mindfulness Based Stress Reduction and is apparently very well-received among psychotherapeutic practitioners in some hospitals.

Among other chaplains, one talked about long walks as a therapeutic, meditative exercise to allow for "clearing my head and having time to reflect on myself and my own spiritual life" (interview No. 13). Another chaplain distinguished between his two lives and how one helps balance the other:

I have an urban life here during the week, and then I have a rural life. So I have a place in the country and, you know, I do gardening in summer, I go

fishing, I raise chickens, you know, so I have a pastoral, pastoral life....We have a pasture, the animals....so that kind of connection with nature is really significant to me in helping me.... (Interview No. 10).

Similarly, another chaplain talked about music as an important outlet:

I love music, and on the way over I almost always listen to...I like classical music best and I always find music as one of God's gifts. I really feel, you know, I don't know; when you think about it, that we are created in such a way that somebody has the gift of composing the music and another person has the gift of playing the music and that our bodies are made in such a way that we hear sounds and it does something to our souls, to our bodies; I found that miraculous, God's work, so I always listen to music and I find that very helpful and that helps me get some sort of nice frame of mind (Interview No. 21).

Several respondents talked about entertaining, life-giving activities such as going to an art gallery, or doing "creative" and "beautiful" things as methods of self-care which help battle work pressures. Sometimes they may do nothing important and let time pass.

As one chaplain said: "sometimes I watch TV and if I choose to watch TV, it is completely mindless stuff" (interview No. 12). The chaplain who had the difficult task of being with the dying man describes her coping mechanism as follows:

I went home from that and I just, God, you know, sleep, sleep is a wonderful thing; I was very upset about it and I just put it out of my mind as best as I could when I got home and I really did and I think I did it ok. I woke up the next day and the sun was shining. I went down to the market. I bought food, you know, what I mean? I let my regular life take over...I have been doing this for a long time, so I am sort of used to just saying: "that has happened, if I do what I wanted, it makes me crazy" and you just move on...I needed to get distance for my own sake... (Interview No. 5).

This example explains the role of body in emotional experience. Taking sleep helped this chaplain stop the continuity of the sadness she was experiencing. Another chaplain used a cognitive technique to cope with sadness: as a result of working in hospital, she has developed "a rapidly decreasing tolerance for exposure to suffering outside of work." Consequently, she does not like to listen to the news or read the

newspaper when it is full of pain and suffering. As she puts it: "I found that I need to limit my exposure to sad things outside of hospital" (interview No. 18).

A few respondents were more intellectually involved in reading and writing short stories, poetry, prayers or journaling as outlets to deal with their feelings. One of the Buddhist chaplains was co-author of a book about traditional Chinese medicine and women's health. By the time I interviewed her, she was conducting two research projects related to healthcare and spirituality. Another chaplain talked about her journaling practice, which is different from a diary:

It is not so much like a diary, but my emotional response to what it is I am experiencing; so diary is more like this happened and then that happened versus my reflection, I mean, there are sometimes when...I call it dying season...because it comes in waves and there are some periods where, you know, there may be six shifts in a row and every day I come to work, somebody dies and I am right there. That is challenging...so I may write about my reflections.... (Interview No. 15).

Holidays, Vacations and Retreats

The spiritual life of chaplains can be nourished by relying on different resources. One of the most important means through which chaplains restore their energy and recharge their batteries is holidays and (silent) retreats. Several chaplains said they use holidays and silent retreats to enrich their spirituality, reflecting and meditating on what is going on in their life. Given the weather conditions in Canada, like so many other Canadians, chaplains like to go to warm, tropical places where the sun shines everyday and the weather is warm. One chaplain said:

I go on holidays and often I go to the Caribbean because I love it there, and it's warm and sunny and I can play in the water and build sand castles and yeah, so I do that fairly regularly usually about once a year... (Interview No. 6).

Similarly, another chaplain said:

When I find that I am not willing to be emotionally available to other people that's when I need to go away....if I get tired, so I am looking forward to my holiday now because I am finding more and more that I don't want to always open up, that I am unwilling to sit and wait and listen... and that's always like that, you know, when you hit the end of the year. I always go in December because I hate the winter... (Interview No. 3).

Apart from such nice vacations, most chaplains benefit from silent retreats.

Described as a "vacation with God" (interview No. 12) by one of the respondents, such retreats are usually characterized by a short, intentional period of isolation in which chaplains disconnect themselves from the outside world, and stay in quiet places with no TV or cell phone use. This temporary withdrawal from the routine, highly industrialized and commercialized world provides chaplains with an opportunity to reflect on their inner lives and attend to their own spiritual needs. Sometimes such retreats are collective, meaning a small group of like-minded people participate in a two or three-day workshop, and attempt to enrich their spiritual lives by participating in contemplative prayers and meditative practices. Such retreats are especially important whenever job pressures are high. A weekend retreat can help in releasing tensions accumulated in weeks of successive intense work.

For a few chaplains living alone seemed to be an advantage: not only do they not have to worry about domestic responsibilities, but they can be absolutely free to do whatever they like. As one chaplain who lived by herself says:

Yes, so being alone and single is wonderful. I don't need to be worried about some kid's lunch or dinner or husband; it's all up to me, so that helps. I am not saying that that should be the case for everyone, but in my circumstances it helps. I don't answer the phone, you know, and sometimes I just have to sleep and that kind of revives me (Interview No. 9).

Psychotherapist and/or Spiritual Guide

An interesting finding, which I found personally surprising, is the number of chaplains who benefit from professional psychotherapy or spiritual guidance. Besides the Muslim and Jewish chaplains (and only a couple of other chaplains), the rest of the respondents said they are either currently visiting a psychotherapist and/or spiritual guide, or have used their services in the past. It is not necessarily a matter of how experienced or inexperienced they are. In other words, some of the most experienced and competent chaplains said they regularly benefit from professional psychotherapeutic or spiritual support in very vital and important ways. Some of the chaplains were spiritual directors themselves. This is again another indication that this job can be demanding and requires various sources of support. Chaplains sometimes need to receive professional help from adjacent fields such as psychotherapy to cope with their own emotions. I did not enquire about details of the relationship between chaplains and their psychotherapists. However, I suspect that by trusting their therapists in a professional sense, chaplains can talk about things they would otherwise have to remain silent about. Sometimes they are so deeply affected by mixed emotions or conflicting ideas that they need to share them with a psychotherapist or spiritual guide to find a practical solution. Several chaplains said they visit with their spiritual director at least once a month. In some hospitals, it is actually necessary to have a spiritual director. Interestingly enough, not only were the Jewish and Muslim chaplains not benefiting from such services, but they were both very vocal in dismissing the need for it altogether. As the Jewish chaplain said:

I have never had psychotherapy and I don't have a spiritual guide but I am very involved in my own faith and I found that's enough. Well, I would say my own observance is very helpful... (Interview No. 21).

Community Participation

Several chaplains talked about the importance of their religious communities in bolstering their spiritual and religious life. Both the Jewish and Muslim chaplains said they are deeply involved with their communities. As the Muslim chaplain said:

I am part of a Muslim community that keeps me engaged; I have some responsibility with them, and we've been together for a very long time. I am a first generation Muslim in a primarily convert Muslim community in North America, whose grandchildren and great grandchildren are now the third and fourth generation of Muslims. So that community's support is important, you know, I can check with someone....my buddy who says to me that you can call me anytime of the day and I'll be there, and it's the same way I have with him (Interview No. 10).

Christian chaplains, too, had responsibilities in their churches and participated in them actively. As already discussed, some of the respondents were ordained ministers in addition to their chaplaincy work. One chaplain talked about sharing her feelings with her religious community as a useful outlet:

I can tell certain stories and I do because I use this work and I use it in sermons and church; I talk about this work a lot, because this is what I do every single day. I preach about every other week, but they know that that's what I do, so I share that... I think that it would be emotionally...it would hurt me to have to leave everything here as far as how I am feeling, so I need to share things, but I put it in a different context, so I take all the goodness that I take from this work back out there to be able to share with people.... (Interview No. 3).

Similarly, another Christian chaplain said:

I am involved in my church. I am an ordained minister in the Baptist Church; I am not the minister of the Church, but my role at the Church is one of support teachers in the Sunday school. I teach Bible studies. Often the pastor asks me to preach, you know, when...so I always get my sermons (laughter); I am careful when I write down the sermons because your sermons always come...have a way of boomeranging to yourself... (Interview No. 7).

Family Life and Social Network

Most of the respondents seemed to be embedded in a network of social relationships from which they receive support. Most of them described themselves as extrovert personalities who enjoy being in the company of others and socializing with friends. Some chaplains are indeed very social and receive satisfaction from such social activities as conversation with strangers. In a sociologically relevant comment, one chaplain said:

I find it more upsetting when I am riding on the subway and not having anyone meet my eyes (laughter), you know, I'm like: "What's wrong with you people? You are all dressed in black." You know, I have been born in England and I have English parents, and...I mean...the English are chattier, all the time expressing everything always in lots of words, even the shy, introverted ones, so I miss that....(Interview No. 3).

Similarly, in the case of chaplains who live with their families, the role of spousal or child support is very important, but it is not, by any means, the source on which chaplains rely to release their work-related tensions. Almost half of the chaplains were living alone and among those who had a husband, wife or partner, almost nobody (except for two cases) shared their experiences at hospital with their mates. Not only is it a matter of confidentiality, but they do not want to upset their loved ones by talking about sad stories. Several respondents said that even if they talk, their loved ones do not understand. One chaplain commented:

I don't think anyone receives support from their family in this kind of work. You can't tell them what is going on; you wouldn't want to burden them. I don't share this stuff with friends; I don't share what happens here with friends because they wouldn't get it (Interview No. 5).

Similarly, one chaplain believed:

My main social interactions are at church where I would never dream of sharing the stuff and my choir, and I wouldn't talk about that there either; people don't want to hear the kind of things that happen here. They don't want

to know and I couldn't tell them anyhow because of confidentiality (Interview No. 1).

But more than that, for some chaplains the job is so sacred and stories are so valuable that talking about them can trivialize their value. As one respondent said:

If I talk I know I would get angry if they [friends] talk low about it because for somebody to lose their child and you say: "Oh, well, you know, this is what life is." No, I don't want you to say that! Life is like that but was it like that for you? You just cut your finger and you thought the world was coming to an end! Because I have seen this with some friends; little things are huge for them so I don't want anything about any of these patients of mine to be ridiculed (Interview No. 9).

The only exceptions were two Christian chaplains whose husbands were in a sense their colleagues: one was a chaplain himself and the other was a church minister. In these two cases, chaplains were able to talk extensively about work-related situations in the house and receive feedback from their husbands. The most experienced respondent was a female chaplain with 26 years of work experience whose husband was a chaplain with similar work experience in another hospital. He was the manager of the chaplaincy training program in his hospital, and they have been apparently able to enjoy a mutual life of work and support. But in other cases, chaplains would not share their work experiences at home, being mindful that their professional life should be separated from their personal one. Spouses, partners, children and friends are great sources of support in general. They are important to fulfill the basic, fundamental needs (love, friendship, belonging, connectedness, etc.) we all have as human beings. However, they are not supposed to help chaplains in battling work-related stresses. This can be a reason why a great number of chaplains have a psychotherapist or spiritual guide.

One chaplain talked about her husband as the greatest source of support not because he helps her cope with work difficulties, but because he has been a great friend and

companion: "when I see my husband waiting for me in the parking lot at the end of a long day, I feel blessed" (interview No. 1). Talking about her family life, another chaplain seemed full of pride in being able to stay in one marriage for more than 40 years, something I thought of as a record in North America and congratulated her for. For another chaplain, being a wife, mother of young children and performing the majority of the housework were already enough to prevent her from thinking too much about work:

My children are very small; when I get home I don't have time to think about work. I mean I am completely overwhelmed with homework and driving them to lessons... (Interview No. 2).

Several chaplains who had children considered their children (and grandchildren) a great source of joy and satisfaction. One of them said:

I just cannot conceive of expecting my children to give me emotional support. But they do by their very nature. And they do because I know they love me and that they think what I do is pretty wonderful even though they wouldn't touch it.... I guess what I am trying to say is that I don't go home and say: "Oh, I've had a bad day," because I don't think that's got any place there (Interview No. 3).

Similarly, another chaplain said:

My grandchildren are a great source of comfort, so, you know, you have sort of a challenging day and it's on the opposite end of life spectrum, you know, here you see the palliative care and people struggling with life and at the other end I come home and they are little and everything is a mystery and a wonder and it's quite beautiful and it helps to balance it.... (Interview No. 21).

Three chaplains (two females, one male) also talked about their dogs as great sources of joy. Walking the dog is a desirable exercise for many people in North America, including three chaplains in this sample.

Of the three male chaplains, one was married, one was living with a partner and one was single. An interesting observation was that the male chaplains seemed to receive a

kind of maternal support from their mothers. Two of these chaplains had their mothers living with them and were grateful for their support. As one of them said:

My mom lives with me here in the city and my family is also in the city. So when my mother notices that I am coming home late, like three evenings a week, she asks me so “what is going on?” and she reminds me I need to take care of myself....(Interview No. 10).

In the case of single chaplains with no children, friends and family members, especially sisters, could be sources of social support. I found that those chaplains who never married and stayed single throughout their life were more committed to a religious life, similar to those of nuns and other pious members of traditional religious orders. I was particularly impressed by one of them whose sincerity and humility was very evident. It was not difficult to see how deeply spiritual she was; the depth of her involvement and her sense of responsibility for patients seemed remarkable as well. She agreed to talk with me immediately upon first encounter, and the interview I conducted with her is one of my best interviews. I assume for such individuals there is a strong religious commitment that supersedes other supportive systems. For her the most important resource was:

God, because that's what that is, that is my...that represents my relationship with God...I haven't given vows; I have only given life promises. It is an important part of who I am and what keeps me in the work that I am in, because I feel I have been called to it. So if I have been called to it, you're [God] gonna help me (laughter).... (Interview No. 4).

Colleagues and Co-Workers

In contrast to family and social friends, colleagues and fellow co-workers are important to provide a pleasant work environment in which chaplains can work and release their tensions, whenever necessary. Healthcare professionals, in general, are likely

to receive significant amounts of emotional support from each other. As Pearlman (1999: 117) argues, among care providers who work with trauma victims a significant reinvigorating activity is receiving "emotional support from colleagues." Davidson (2007: 201) refers to this process as "caring for the caregiver." Likewise, James (1989: 19) describes interactions between intensive caregivers as skilled "hard work."

In large spiritual care departments, where several chaplains work together, there seems to be a strong sense of identification and collegiality among chaplains. Such work environments are usually equipped with a safe backstage on which chaplains can draw whenever the job is difficult or the situation is intense. Talking with colleagues is one of the most effective ways to cope with stressful situations. With colleagues, chaplains can look at things in funny ways, joke about them, and use humour to deemphasize the bitterness and difficulty of the work and celebrate the rewarding aspects. As one chaplain said:

I think I am so helped by the fact that my colleagues...we all have a sense of humour, that we can laugh at ourselves when strange things happens... I look forward to coming to work not to see the patients and the families but to see my colleagues because we have a really good time.... (Interview No. 2).

Moreover, some chaplains share their sense of humour with other medical professionals in order to emphasize the celebratory aspect of life even in places where people are at their worst. The following examples illustrate this:

I do a lot of celebrations.... I literally tell people I am a dance instructor and I teach people the ICU happy dance; I teach patients the ICU happy dance...

Interviewer: That would be interesting to see an ICU happy dance (laughter)!

Chaplain: All they have to do is move their elbows and, you know, if lunch was good, if they had good news, if they had a lovely visit from a family member... to celebrate the little things because the little things on a roller coaster ride.... if you don't celebrate up here, all you've got is crummy stuff

and the celebration helps with managing the roller coaster ride and so I teach this to patients and some of them, you know, as they are waiting for surgery I come and I meet them after surgery and we do the ICU happy dance or we do a lot of celebration... (Interview No. 15).

Such practices can be included among the ritualistic techniques of emotion management discussed earlier. Another chaplain says:

I love to go to the chemo clinic; it's for the out-patients. The room is beautiful. There is sunlight usually, radiating right through; the nurses are handpicked for that area of the hospital; they are just happy people. In fact one of the nurses used to dance all the way across the hall of chemo clinic with me. We used to waltz, we used to waltz back and forth plus she put the music on and we dance across the room and, you know, usually I am sent to people who are not doing so well – maybe their cancer has returned for the second or third time and they really need a visit from me.... (Interview No. 17).

Sometimes chaplains share offices with their fellow co-workers and as a result, develop strong bonds of mutual support. One chaplain talks about her colleagues:

I really like my colleagues here because, really, they are the only, only people that understand why sometimes it's fun here, and don't think it is in bad taste to find it fun, and they are the only people that really, truly, can understand how it can bolster my faith... (Interview No. 3).

Similarly, another chaplain says:

My sister and I talk a lot. We usually talk once or twice a week on a.... I don't necessarily talk about my job because of the level of confidentiality but I can say that: "I had quite an intense day today." But with my colleagues I debrief all the time, you know, in terms of my work and they are always there if something, you know: "you won't believe what I just"... that kind of thing and we use each other often, Alex and I, in particular, because we share one office but I always, you know, if I have something I go to somebody else as well... (Interview No. 6).

Chaplains may also have colleagues outside of the hospital that they can call and talk to whenever there is a need:

I had a patient, a psychiatric patient, yelling into my answering machine for about five minutes, non-stop, about what an awful person I was. She was very sick, on and on and on. I got very upset when I heard that so I phoned my

friend who is a parish priest in an Anglican church; his work is related...it is not exactly the same but he is somebody that I can phone and talk about something. I have had to get feedback and he is very funny and so....I called him and started saying... but he began to laugh and said: "Listen, honey, there is a reason she is on psychiatric floor. It's okay (laughter)".....oh yeah, ok....the perspective that he brought.... so I mean I think I am lucky in that I've got lots of friends like him, not just those who work here, but I have been in chaplaincy for so long, so most of the chaplains who work in Toronto....so if I really wanted to call somebody I could (Interview No. 2).

The above examples explain the importance of colleagues and other healthcare professionals in providing support and managing emotions. One of the most important elements of successful healthcare delivery, pointed out by Davidson (2007) as well, is teamwork. Such teamwork is not limited to collaboration for providing care, but supporting each other during care provision as well. Chaplains particularly rely on their colleagues in spiritual care to receive emotional support.

Educational and Occupational Workshops

Apart from debriefing and informal chats, chaplains participate in a great number of educational workshops, occupational training courses or meetings with other colleagues to not only reinforce their institutional role, but also to reflect on the job and receive insight. Such meetings and workshops provide what can be called *self-presentational strategies of interaction* to make connections with colleagues:

Our chaplains meet once a week for something called Dialogue and we begin with the reflection; we take turns and each person has a different way of doing it. They bring over reflections which lead into some discussion about that, which leads to a staff meeting. Yesterday, for example, the chaplain who led the Dialogue, she brought something on wonder; she brought an experience she had with her granddaughter and then read something from the book on wonder and then we talked about that....so that's another way of coping with our, you know, the situations we have because sometimes we can't bring to that meeting... if we've got a patient we are concerned about. If you have got a woman upstairs who is just losing her baby, you know, a 25-week pregnant,

that's one of the hardest things to deal with. So being able to talk to others, about it, about how it's affecting you... (Interview No. 4).

Similarly, another chaplain from another hospital says:

We have a monthly debriefing session. Myself and the social worker together organized the debriefing session for staff where they can come and discuss any issues they want. Sometimes we have a set agenda that we want to do and sometimes it's a set agenda to get our minds off all the work related stuff and just do something fun in these debriefing sessions and sometimes it's to sit down and say, you know, so we had... Miss. Jay was here and, you know, for family it was difficult, let's talk about what it was like to care for Miss. Jay and for her family (Interview No. 13).

Similarly, another chaplain:

I have been doing a three-year transpersonal psychotherapy training program which is extremely experiential, so I have been through that doing a lot of my healing and growth work, developing a lot of self-awareness...we have a number of teachers who focus on different aspects of transpersonal psychotherapy teaching us different specific techniques and scales, and then over the course of the three years, more and more we start to facilitate work for each other. So we go to a class situation and somebody would volunteer to be "client" and someone would be volunteer to be "therapist;" those two would get up in front of the class and the teacher and they will do a piece of therapy work and get feedback from the teacher, from the students, so there was both the opportunity for me to do my own personal work and to practice facilitating a piece of work

Interviewer: It could be confessional as well? Like you have to talk about your inner reflections and feelings?

Chaplain: Very much, and I feel extremely fortunate because it's a very small institute where this program is offered and there is quite a strong community, in a spiritual sense of the word that is developed.... (Interview No. 19).

Finally, another chaplain took a course about anxiety and depression called cognitive behaviour therapy (CBT). As part of occupational training, such courses are supposed to prepare healthcare professionals to better deal with anxious and depressed people. However, by taking these courses, the chaplain was also able to benefit from them by applying them to her own problems.

Previous Life Experiences

For four chaplains, in particular, their life experiences provided them with a kind of *emotional capital* (Cahill, 1999; in Peterson, 2006; Schweingruber and Berns, 2005) upon which they rely in order to enrich their spiritual journey and to perform their job effectively. Not only are such personal experiences indicative of human resiliency and the inner strength to battle grief, pain and suffering, but they can also inspire chaplains to engage in *altruistic exchange of emotional energy* and perform what I have already described as *selfless emotion management*. One respondent believed:

I would say this work is not made for everyone, it just isn't. I have been traumatized in my life; I have had a lot, I had trauma, so I don't think seeing sadness here overwhelms me. I think sadness exists and bad things happen. And I think it's part of our work living life, to walk forward, to help ourselves heal and help other people heal... (Interview No. 3).

Another one also believed:

This [job] came very late to me in life. So I think I pretty much worked everything out before I got here, before I was ready for the position. I didn't come to it young. I have had a lot of life experiences; I worked through a lot of things. Now that I look at back – because I do have a little more wisdom with age – I never would have been ready for this job until now. There are lots of people who are younger than I am, who are chaplains. When I was doing my CAPPE I was in with some 21-year-old trainees who shocked me because I thought: "Wow, how amazing they are ready! Maybe ready at 20! But boy, God saved the best for me for last (Interview No. 16).

And the third chaplain in this category believed what she sees in the hospital everyday is nothing compared to what she went through in her personal life. After losing a husband because of critical illness, she embarked upon a healing journey that was not easy:

Interviewer: You mean you have had more difficulties in the past?

Chaplain: Oh, yeah absolutely. None of this is ever going to be as bad as experiences that I have already survived and that inner knowledge of, you

know, I went through that experience. I went through grief. I went through the full gamut of everything there. For me nothing that happens here is going to be as hard as what I have already survived and healed from and come through; so that gives me a very strong emotional, spiritual core of self-awareness, coping strategies, and an ability to empathize and connect with various people that I work with, whether it's family members, whether it's medical team, physicians, you know, it's lots of different facets (Interview No. 15).

Finally, the story of the fourth chaplain is also striking. The following information was obtained through an "enrich question:"

There is one thing I want to tell you. In 2006 I was on-call for the hospital and it was the most difficult call I ever received in my life because it was my own family: my brother and sister in law were involved in a car accident and both of them were dead. And that was...I wanted to let you know that, you know, it's not just them, the patients, that go through tragedy or trauma or problems....I took the call. I was paged by my family up there to tell me that my brother and my sister in law have been killed by a terrible accident....

Interviewer: So you had to provide support for yourself first and then others?

Chaplain: Yeah.

Interviewer: How could you survive it, may I ask?

Chaplain: I was in shock for two years. You know, when you don't believe something actually happened you can be pretty cool (laughter); if you don't believe it really, but even after going through the funerals, double funerals... but it was not until on Good Friday, which is one of the holiest holidays in the calendar....yeah...but it has made me stronger, it has made me a stronger person

Interviewer: You went through the grief process and released the grief and at the end you were able to come to terms with it?

Chaplain: Well, I realized something: I am not immune, I am not immune from what another goes through and that is good. It's good to know that what happens to you could happen to me, and when you go through with it with faith and hope then it can be used to help another person along the way because other people had family members killed, but they have gone to me...because some people think chaplaincy...we are born in this position because we have never suffered anything, but I think just the opposite is true, sometimes we have been through our own stuff. We can be stronger. So that's about it (Interview No. 17).

Chaplains' Emotional Make-up

In this chapter, I tried to explore different strategies and resources chaplains may utilize in order to function efficiently in both work and life. However, the most important finding with which I want to end my argument is chaplains' own mentality and emotional make-up, their approach and the kind of attitude they hold toward their profession. It was important when asking about emotionally challenging aspects of the job, that I would also have chaplains talk about emotionally *rewarding* aspects, so that a better understanding of a job which is not exactly attractive for many people would be achieved. I wanted to know where the gratification comes from that keeps chaplains in this profession. After all, what is horrible for most people, namely, illness and death, is chaplains' everyday work material. For many people, hospitals are synonymous with bad news¹. Most frequently associated with blood, white uniforms, medical instruments, pain, suffering, illness, and ultimately death, hospital is a place to be avoided as much as possible. But hospital chaplains tend to look at these notions differently. They do not enjoy illness and death but chaplains gain satisfaction from helping people who are struggling with them. Even though the job is often full of sad stories, and even though situations are stressful, chaplains feel emotionally rewarded because their emotional make up has developed in such a way that they gain pleasure (not in a hedonistic way but in a fulfilling way) from being in the presence of troubled people as care providers, helping them go through their hospital journey. Therefore, performing emotion management per se is not necessarily draining.

For many chaplains, the awe and richness of life reveals itself precisely at such difficult times as death or the moments before it. Although it can be painfully tragic, it

¹ Perhaps one of the few occasions in which good news is given in a hospital is childbirth.

can also bring joy and fulfilment for lives that have been fully lived, survivors that are very proud, family members that are reunited and so forth. The decisions that are being made around death and end-of-life issues can be a source of inspiration as well. The courage, simplicity and honesty with which some people accept their fate and come to terms with the reality of their life (or lives of their loved ones) humble chaplains, and provide them with great examples of strength and resilience. Therefore, "how can you deal with death and dying all the time?" would be the wrong question to ask a professional chaplain. Instead, one should ask: "what is it that inspires you to do this kind of work?"

Oh, you know what? I think they call it *vicarious resilience*; when I hear how patients are able to be with some of the things that have happened to them in their lives, when I hear the resources that they draw on, their capacity to still smile, to be here, to have something to keep them going, I think for me – and that's everyday – it is always inspiring and such an honour to hear their stories and to really appreciate the human capacity for acceptance, healing, flexibility, to find meaning and to find purpose or not to accept defeat, you know....(Interview No. 14).

In explaining a rewarding experience, another chaplain said:

I remember one case, a young man in his thirties, who was going to....they were going to let him go. He had a bad snowmobile accident, but right to the end he talked, so I just couldn't...the mother called me and asked me to pray for him, so I went and stayed with them until he died. And I realized that, you know, for the mother to say "why am I doing this," you know, "I love you;" I think it was hard for her to say that because the parents were divorced and they both came...I think the son was closer to her and that one case was too difficult, more difficult than the others in that, gosh, the others are brain dead, but he was still talking and what he was saying was: "It's OK, mom, I understand that"....

Interviewer: We were supposed to talk about the rewarding aspect of your job?

Chaplain: The reward is what I learn from the families to accept what has happened and that helps me treat life with more respect and then in my own case if things

happen it's like: "well, this is how they dealt with it," you know, they help me in my own life.... (Interview No. 9).

Similarly, another chaplain comments:

This kind of work, you know, people don't go to it....people often think that it must be difficult for someone to be around death and dying all the time and it certainly is. It can be very sad at times but, you know, in some ways I feel I was made for this kind of work; so I couldn't change it but I can talk to somebody about the death of their spouse, you know.... I think I have a certain inclination towards the work and so what might appear to others to be emotionally draining is in fact some of the things that motivate me (Interview No. 18).

And yet another respondent:

Knowing that you have made a difference in someone's life is energizing, so some days I come away from a challenging situation knowing that I have done a good job, knowing that I have made a difference in someone's life, knowing that I have been able to be the support they need or find the support they need and I come away feeling really good about that, even though it was a sad time (Interview No. 12).

For most chaplains the intimacy, trust and emotional bonds that are made between them as care providers and other people (either patients or family members) is an invaluable reward. Knowing that chaplains do not usually deal with patients who are in routine care and a peaceful state of mind, whose hospitalization is not extremely stressful or painful, I would like to reemphasize that it is rather the traumatized and the dying who receive chaplaincy support. Hit by an accident or a life-threatening diagnosis, such people may lose emotional control and require spiritual support. Struck by life's surprising twists and racked by uncertainty, people's need may be someone in whom they can put their trust to simply sit and talk about what is going on. The role of the chaplain is that of trustworthy listener who is there for whatever issue people want to talk about. The immediacy of the situation is remarkable. And the emotional experience is very unpredictable. As one chaplain says:

It's very hard to say, a lot of the feeling stuff can come when you don't expect it, you know. It can be just a kind of surprise, so it catches you rather than you anticipating it, but I think it is just an unexpected thing, you never know what you are going to feel because there can be very great satisfaction in a very sad encounter; you feel very satisfied if you know that you have helped someone finding meaning in their faith. Even though it is a very sad situation, you find a great deal of satisfaction... (Interview No. 5).

Chaplains may not be able to fix the problem. In fact, in most cases it is not fixable. But chaplains can be compassionate listeners to people whose defence mechanisms are lowered and whose problems are overwhelming; patients want to and need to talk about their problems, not to fix them, but to feel less pain:

I don't make it less difficult by fixing it. I make it less difficult by joining them [grieving family members] in their helplessness, their sadness. It's like magic, but it works, if I join somebody in their sense of loss they feel supported even though the circumstance doesn't change (Interview No. 11).

Sometimes patients are at the end of their life journey and feel an urge to talk about what was meaningful, valuable, rewarding or significant in their life. Sometimes there are family members who want to talk about the value and significance of the life of their dying loved one. In any case, chaplains are present for this as well. Such roles provide chaplains with a unique opportunity to be exposed to the most intimate and personal reflections of people on matters of life and death. It can indeed be fascinating to hear about the most valuable elements of a person's life. In a matter of few hours, a chaplain may become so close to the inner life and private relationships of a patient that she begins to hear confidential stories never told before, stories that would otherwise take a tremendous amount of effort, time, and trust before they were heard. In most cases, the role of the chaplain as trustworthy listener is taken for granted. A chaplain cannot be categorized into a standardized medical role because there is not a similar procedure to follow for each patient. Every relationship and every situation is unique. Consequently,

individuals who feel vulnerable may open up and talk about their most important issues. It should not come as a surprise that for many chaplains those situations that are the most emotionally draining can quite often be the same situations from which they receive the most emotional reward. One respondent said her most rewarding encounters are the ones in which people cry:

You know, often when people cry – it sounds very strange – but I love the intimacy; people tell me so many things and I love it when they feel, for a little bit of their journey, they are not alone and they have an opportunity to share their life with me....(Interview No. 15).

Similarly, another chaplain said:

It's very rewarding, the privilege of connecting with people on that level – they let you in, in a way that they won't let any other professional in I think, you know. You say who you are and right away they want to talk about something deep that is happening; that is a huge privilege and you get to listen to it, you listen to it with a certain ear to help them. It makes me *powerful* and *wonderful*, so I love the work; that's why I am reluctant to just kind of retire (Interview No. 5).

Similarly:

I have the privilege of entering some of the most vulnerable moments of people's lives and being received and welcomed in that place...they share with you the most intense pain and they trust you with that part of them that a lot of people don't see and you hold that in reverence (Interview No. 4).

In summation, people come to hospital with a mixture of negative emotions and often automatically assume that the chaplain is there to listen to them, that she can be trusted professionally. As a result, they open up and share confidential things that, as one respondent said, they may never have shared with anybody else before. This, in my opinion, makes hospital chaplaincy not only a very rich and deep profession in terms of emotional experience, but gives chaplains a positive sense (e.g. "powerful, wonderful") of who they are: spiritual care providers with high levels of self-respect and self-esteem,

moving back and forth between people's lives, trying to act as a source of help and support. It is this perspective with which chaplains look at their job and embrace it. Performing emotion management in such a situation, helping people realize their spirituality and inner strength, developing emotional bonds and forming intimacy, make emotion management a rewarding practice in hospital chaplaincy. It is entirely at odds with Hochschild's conceptualization in which emotion management is a means of making profit for business corporations, alienating workers from their true selves.

Chaplaincy and Health-related Issues

Although helping people manage their emotions and providing emotional support is rewarding for chaplains, it should also be pointed out that being attentive to the needs of people who are in pain can threaten chaplains' own health. Many chaplains are likely to find their health in jeopardy. In fact, one of the respondents provided valuable information about several of her colleagues, whom she knew personally, that have been seriously ill as a result of working in hospital chaplaincy. She talked about one chaplain diagnosed with cancer, another one who had to have a liver transplant, a third one with a degenerative disease and a fourth case with bowel cancer. It is important to keep in mind that these were only the cases of which one chaplain with nine years of work experience knew. None of them, she said, have been able to come back to work yet, and the one with a degenerative disease has moved on to another profession. I asked if she would be willing to put me in contact with any of them so that I could interview them for this study. Although she agreed, I did not receive any emails or calls. As it turned out, some are still sick and some have moved away from Toronto. In addition to this respondent,

another chaplain also talked about a previous colleague who had to leave the job permanently as a result of burnout during the SARS epidemic in 2003.

Conclusion

Among the chaplains whom I interviewed for this study, there seems to be a high level of job satisfaction. Health conditions and quality of life also seem to be good for the most part, except for a few full-time chaplains. As already discussed, one important reason chaplains work part-time is to protect their health and avoid occupational hazards such as burnout and fatigue. I would argue that hospital chaplaincy can be a very intense and difficult job, not because of the enormity of pain and suffering chaplains see in their everyday interactions with people (far from it, the job is very rich in terms of emotional experience), but because of the workload to which some full-time chaplains are committed. Therefore, the kind of emotion management that chaplains perform is not similar to Hochschild's conceptualization in which emotional labour is completely detrimental, serving only to increase material benefits of a business organization. Such a view of emotions in organizations can be indeed very limited in its scope and applicability. Chaplains in this study enjoy their job and find it emotionally rewarding.

However, there does seem to be a difference in the health condition of full-time and part-time chaplains. Quite a few full-time chaplains seemed exhausted and close to burnout. For example, being asked if she has ever found herself in a situation where she thought she should be temporarily away from her job in order to protect her health, one of the full-time chaplains responded:

Actually, quite frankly I feel I am there right now, I feel very much that I am there right now because I am getting burnout a little bit, and that's about

going home when feeling just really discouraged... A sign of burnout is when you sit in your office and you don't go out there to see the patients, you sit in your office and kind of wait to see if you get paged...yeah, I am struggling with burnout right now because I do find myself reluctant to go up stairs... (Interview No. 5).

Similarly, another full-time chaplain in answering the same question said:

Actually, I am thinking about it right now because in the last fall I have been sick four different times with sinus problems and throat problems and my immune system just seems shot and I am wondering if part of that is, you know....

Interviewer: Because of your job, I mean what you do?

Chaplain: Yeah, because right now I do feel tired; I feel burnout somehow and I am wondering if the antibiotic that I have for this doesn't work, then I will go back to my doctor and ask for time off.... (Interview No. 7).

In summation, I may reemphasize that instead of the emotional difficulties of the job, it is the huge workload from which the above chaplains suffer. All chaplains, even those overloaded with work, said they love their job. It is 40 hours of intense weekly work in one of only two trauma centers in Toronto that is overwhelming.

Chapter Seven

Conclusion and Discussion

This chapter summarizes what I attempted to do and what I learned over the course of this study on emotion management in hospital chaplaincy. I begin by revisiting the research questions and reflecting on the goals of this study. I then summarize the methodology and methodological issues. The major section of this chapter is devoted to highlighting the substantive findings and contributions, the place of this study in the existing literature and its implication for chaplains, healthcare policy makers and researchers of emotions. This is followed up by combining an assessment of the limitations of the research and a proposal for future research. I also include a discussion of credibility criteria.

Research Questions and Goals

In the first and second chapters I described my theoretical framework and explained why I chose hospital chaplaincy as a topic of sociological research on emotions. Given the importance of the healthcare system for the well-being of society, I decided to study a category of healthcare professionals whose job requires emotion management. Although this concept has been extensively studied among different healthcare professionals, hospital chaplains have rarely been subjects of sociological research on emotion. I was also interested in the work of chaplaincy because of its relevance to religion and spirituality. As I demonstrated, beyond religious rituals, chaplaincy work is about developing intimate relations and providing emotional support. This is especially significant in an era of medical

supremacy in which some physicians look at patients impersonally, as if they are only a physical, mechanical body. To justify my model, it was argued that the interactional/symbolic interactionist approach, as elaborated by Hochschild, is useful because in her theory, Hochschild discusses emotion management and emotional labour in relation to the feeling rules of the organization in which emotions are managed. Moreover, Hochschild is very concerned with the personal costs of emotion management for service workers.

However, Hochschild's conceptualization of emotion management seems to be inadequate to explain the complex and multi-dimensional nature of emotion management and the different techniques that workers may use in different organization and different contexts. Phenomenological and ethnomethodological studies of emotion management are useful to reveal some of the shortcomings of Hochschild' interactional model. I utilized Denzin's phenomenological understanding of emotion as "lived experience" for this purpose. In Denzin' theory, the body and bodily ways of being are of central focus, and emotion is a product of the social interplay between inter- and intra-personal interactions (1984:54-57). Emotionality is a historical, contextual process that is influenced, among other things, by interpretations and self-conversations during social interaction. The third element of my theoretical model was derived from ethnomethodology as a strategy to examine the everyday practical reasoning underlying human activities. Because of the importance of chaplain-client interactions, I utilized an ethnomethodological approach to study the structure of social interaction and different ways of creating

socially meaningful communication to achieve what ethnomethodologists refer to as an ongoing accomplishment.

Therefore, by borrowing useful concepts from Hochschild's interactional theory and incorporating them into a theoretical framework that was charged with phenomenological and ethnomethodological interpretations of emotions, I designed a theoretical and conceptual model with which to study hospital chaplains.

In order to explore the world and emotional lives of chaplains, I described different work situations in which chaplains are likely to experience strong emotions, and the emotional difficulties/challenges chaplains may encounter as a result of working in hospitals. A spiritual approach vs. a medical approach, the emotional identification with the situation, baby death and emotional dissonance were specifically discussed to indicate how difficult the work of this profession can be. I wanted to know what resources and supports are available to chaplains. Part of that agenda made it necessary to look at the impact that chaplaincy work has on chaplains' personal emotions. My theoretical focus inspired two additional lines of inquiry: what are the feelings rules that govern chaplains' experiences? (Are they subject to different and conflicting feeling rules?) And to what extent are different techniques of emotion management, or different types of emotion management, visible in the work and interactions of chaplains? My goal was to collect rich, qualitative, empirical data that would help answer these questions and that might lead to new and important theoretical insights.

Methodology

A candid and thorough discussion of my research methodology was presented in Chapter Three. I developed my recruitment plan after choosing Toronto as a proper research site with many medical institutions. There is a list of Toronto Hospitals on Wikipedia with 23 names. I visited 19 hospitals and was able to interview 21 chaplains. I constructed the conceptual framework of this study by reviewing the literature on emotion management, and by talking with a few hospital chaplains before I actually wrote my PhD proposal. Although there was a deductive element to this project in that I had clear ideas at the beginning about the questions that needed to be asked, the main character of this study was exploratory. The fact that I remained open to discovery facilitated the emergence of new conceptual categories. As a result, my interview guide changed several times after the first interview.

Initially, I decided that semi-structured in-depth interviewing would be the main data collection strategy, supplemented by ethnographic work based on participant observation. Unfortunately, despite their best intentions, managers of chaplaincy departments in hospitals where I wanted to do ethnography misled me and made it impossible to obtain timely ethics clearance. REBs put additional obstacles in the way of recruiting chaplains for interviews. Although I admit that I probably underestimated the difficulties of the recruitment process and receiving permission to do qualitative research in healthcare institutions, I had no idea that by giving a consent form to a chaplain, my name could be distributed all over Canada as a student conducting unauthorized research.

As I explained in detail, the subsequent problems I encountered after the ethics fiasco prevented me from interviewing more chaplains. In addition to that

problem, I had unpleasant interactions with those REBs to whom I applied for ethics clearance but was not given any. Researchers who want to conduct research in Canadian healthcare institutions can benefit from this rather personal information that I provided about problems and difficulties encountered during my fieldwork.

Substantive Contributions

Chapters Four, Five and Six explored the emotional experiences that chaplains go through as a result of working in hospitals, the problems they may encounter in performing their jobs or managing their emotions and the resources or strategies they use to cope with them. Chaplains encounter a diverse range of situations in which different emotions are likely to be aroused. Chaplaincy work is highly unpredictable precisely because the situations in which chaplains interact are varied. Most chaplains value this and look forward to unpredictable encounters with different people. All situations, however, share one common similarity, which is that they are filled with intense emotions. Quite often, people are overwhelmed and need comfort.

The chaplains' role is to be a compassionate care provider who listens patiently and tries to identify the matrix of emotions in which people are caught. As such, chaplains are supposed to be emotionally present, available and attend to people's spiritual needs. Like sponges, chaplains soak up people's emotions, name them and process them so that a healthy release of stress and tension can occur. As I explained in detail, creating effective communication is vital in the work of hospital chaplains. By displaying role distance to their title as "chaplain" and defining themselves as "spiritual care providers," some chaplains manage to provide a safe social space in which clients

feel free to open up and talk. But more importantly, chaplains are equipped with interactional competence, that is, the ability to initiate interaction and direct conversation in ways that patients become motivated to cooperate and talk about their problems. By making a kind of *interpersonal emotional bridge*, chaplains try to cultivate what I described as *contextual spirituality*.

As spiritual care providers, chaplains identify and bring to the surface whatever sources of strength are available to people in order to help them cope with their problems. Clues that people give are essential to help chaplains obtain an indexical and contextual understanding of the situation. In other words, the type of spirituality chaplains seek to promote is very much dependent on the context and situation of their clients. It is important for chaplains to initiate conversations and address issues that are relevant to clients' spiritual lives. Speaking from an ethnomethodological perspective, it can be argued that success in creating effective communication helps chaplains achieve an ongoing accomplishment in performing their jobs and providing support for emotionally overwhelmed people, while inability to do so leaves them frustrated and with a sense of powerlessness.

An important aim of creating effective communication is to identify, name and release negative emotions, while the other important aim is to elevate positive emotions. Prior to embarking upon emotion management, chaplains may emotionally identify with the situation, imaginatively taking the role of their clients to feel what they are going through. By appealing to their own personal experiences and using past memories as *emotional transmitters*, chaplains may create a kind of emotional capital, engaging in altruistic emotion management and an exchange of emotional energy.

These processes can in turn be activated by different techniques of interpersonal emotion management. Perhaps more than any other healthcare professionals, chaplains engage in a type of interpersonal emotion management that I termed *selfless emotion management*. Even though chaplains may receive some emotional rewards from interaction with patients, they do not expect comfort or emotional support from patients. On the contrary, in helping a patient they may go as far as to jeopardize their own health and safety. *Strategic submissiveness* was explained as just one example of such selfless emotion management. In order to perform their job, chaplains appeal to different *strategic interventions* and *support practices*. They also rely on a number of supportive resources to protect their mental health and well-being. Chapter Six was specifically dedicated to describing these resources as they are visible in the work and lives of chaplains. As part of that chapter, I argued that in addition to the three techniques of emotion management described by Hochschild (cognitive, bodily, and expressive), chaplains may also manage their emotions by innovative, idiosyncratic rituals. This method of emotion management was described as *micro daily rites of passage*. Other ritualistic methods include *institutional scheduling of emotion management*, and developing *routines*.

Physical contact and crying were specifically examined to see if there are feeling rules telling chaplains how they should make physical contact or express tears. Like other organizational roles, hospital chaplaincy is influenced by the feeling rules of the institution in which chaplains work. To summarize the definition, feeling rules prescribe the direction, intensity, and duration of emotions (Hochschild, 1979: 564). Despite their pervasive influence, feeling rules are not usually noticeable. As Hochschild (1979: 563)

explains, we may only become aware of their presence when a feeling that is expected comes up short. I was able to discuss feeling rules with regard to hugging and crying. Most chaplains said they would be reluctant to hug others, especially people of the opposite sex, because of the cultural, gender and religious boundaries that monitor our everyday interactions. Physical contact was one of those rare occasions where gender issues arose.

In terms of crying, there seems to be clear rules as to how chaplains should express tears: all chaplains believed intense crying (e.g. sobbing) is inappropriate and unprofessional. Not only do chaplains believe that sobbing should not happen in front of patients, but they also believe they should not allow themselves to display such a loss of emotional control. Moderate forms of crying (e.g. shedding a few tears) were acceptable if they were naturally felt and not faked. Moreover, a dramaturgical analysis shows that crying can be interpreted as a form of *strategic signal* that interpersonal emotion management should be initiated.

Hospital chaplaincy is energy draining. It can put chaplains' health in jeopardy. There are situations in which chaplains are likely to be challenged more than others. These situations were discussed in terms of spiritual approach vs. medical approach, emotional identification with the situation, dealing with baby death, inability to create effective communication, and emotional dissonance. In addition to dealing with pain, suffering, and death, some chaplains may have to cope with anger and frustration over medical decisions made by uncompassionate physicians or rude nurses. It was shown that a *dynamic of sadness-anger-powerlessness* may be produced as a result of dealing with such situations frequently.

Emotional identification with the situation could negatively influence chaplains' emotions. Applying a symbolic interactionist perspective, I showed that by taking the role of others in particular cases and identifying with specific situations, chaplains may become emotionally affected and feel momentarily incapable of performing their job.

As part of their job, chaplains have to deal with death and dying patients. While their job requires that they regularly appear at the bedside of dying patients, nevertheless some chaplains feel challenged only when baby death is involved. From a phenomenological perspective, I was able to see how bodily ways of being (e.g. being pregnant) influenced chaplains' emotionality in these situations. Gender can play a role here as well.

Emotional dissonance, as a common phenomenon happening among healthcare professionals, was present among a number of chaplains in this study, including those with managerial positions. According to the definition, emotional dissonance happens whenever there is an inconsistency between feeling rules of a particular situation and the personal opinions of the worker. In other words, when there is a clash between the personal and professional values of worker performing emotion management. Being critical of subordinate staff, even if their performance is unsatisfactory, was difficult for chaplains with managerial positions because their professional expectations discourage them from expressing criticisms. Likewise, some chaplains complained about other medical professionals, who do not recognize and appreciate the value of spiritual care, and expect them to be always prepared for intense emotional involvement while on the job. By articulating these and other emotional problems that chaplains may encounter, I

tried to draw an *emotional map* for hospital chaplaincy, in which *emotional hotspots* were specifically stressed.

Naturally, chaplains have to rely on a variety of resources in order to protect their health and well-being. I described different resources in detail. As a strategy, a great number of chaplains work part time, spending no more than two or three days a week at the hospital. As a source of support, a lot of chaplains see psychotherapists and/or spiritual directors on a regular basis. Family and social friends are also valuable sources of support, yet they are not expected to directly help chaplains release their work-related tension and stress. In fact, except in two cases, all chaplains said they rarely talk about what is going on in the hospital at home. Not only are they mindful of confidentiality, but they do not want to burden their family members. Instead, they rely on colleagues and other professional support providers to cope with job difficulties. The spiritual life of chaplains, in the form of their religious rituals and meditative practices, are extremely important to maintain high levels of emotional well-being.

Last but not least, it is the chaplains' own emotional make-up and attitudes that are essential in enabling them to not only perform their jobs, but also receive satisfaction from a profession which is otherwise intense and draining. Working full-time and providing spiritual support in hospitals where critically ill patients are admitted can be exceptionally overwhelming. It can put chaplains close to burnout and jeopardize their health. At least three chaplains in the sample were on the edge of burnout and expressed symptoms of fatigue. Although they felt positively about their job, these chaplains seemed exhausted with the workload. In one case a chaplain was thinking about early

retirement so that she can perform only volunteer work and in another case, the chaplain was thinking about a six-week leave to recover from fatigue and rebuild her health.

The findings of this study are in agreement with a few studies on hospital chaplaincy in certain ways. For example, Taylor et al. (2006), Flannelly et al. (2005b) and Crossley (2002) discovered high levels of job satisfaction among the chaplains in their quantitative research. Similar to these studies, my research reveals a direct relationship between occupational hazards such as burnout and workload in the sense that the more hours chaplains spend working, the higher the chances of becoming stressed and burnt out. Moreover, Taylor et al. (2006) and Flannelly et al. (2005b) found a direct relationship between occupational hazards and the frequency with which chaplains visit traumatized patients. In accordance with these findings, my results suggest that working in hospitals where trauma victims are treated increases the chances of compassion fatigue and burnout.

Similar to what Crossley (2002) uncovered, chaplains in my research paid special attention to their spiritual life and their relationship with God. Not only was their spiritual and religious life an important source of satisfaction, but it was also an essential part of the reasons they chose this line of work.

In contrast to previous studies, however, my research explored multiple resources, strategies and supportive means that chaplains may rely on in order to perform their job. As I argued in Chapter Two and Chapter Three, quantitative studies often fail to consider the important factors that lead chaplains towards higher job performance. Also, previous studies have not made it clear in what ways chaplain's health can be influenced by their work. One important finding of this research was that working in chaplaincy can increase

the risk for serious illnesses. One of the respondents was able to mention at least four colleagues who were diagnosed with critical or chronic illnesses.

In terms of its place within the existing literature, this study is part of a growing field in the sociology of emotions, namely, the sociology of emotional labour. As discussed in Chapter One, sociological studies on emotional labour are either concentrated on the organization in which emotional labour is performed, or at the personal level focusing on the consequences of emotion management for individual workers. The first line of research has been primarily quantitative, while the second is qualitative. My study belongs to the second line of research, where personal consequences are important. However, instead of measuring the personal consequences of emotion management by standardized instruments such as *The Maslach Burnout Inventory* (2001), I listened to what chaplains had to say about the emotional difficulties and challenges of their jobs. I combined insights from symbolic interactionism with phenomenological, ethnomethodological and dramaturgical approaches to analyse and describe the emotion management performed by hospital chaplains. The findings of this study can enrich our understanding, from the qualitative perspective, of emotions as they are lived everyday by chaplains in healthcare institutions.

Credibility Criteria

In this section, I will discuss four credibility criteria that are appropriate for evaluating qualitative research: transparency, trueness, consistency and communicability.

Qualitative researchers should make their methodology transparent (Rubin and Rubin, 1995:85). Mindful of this guideline, in Chapter Three I offered a behind-the-

scenes look at the research process. In this candid account, I believe that I conveyed the following: (1) I responded appropriately to unforeseen circumstances; (2) given the available resources and problems encountered, I made sound sampling decisions; (3) I was sensitive to ethical issues during interviews; and (4) I facilitated disclosure in each interview.

Related to transparency is the notion of theoretical candour, which is an honest account of how the researcher arrived at an organizing framework (Lofland and Lofland 1984: 151). I explained that there was a deductive element to this project in that I began the interviews with the intention of applying three theoretical perspectives. Based on a detailed literature review and an initial empirical investigation, I had determined that this was a useful theoretical framework. However, this study was primarily exploratory.

The second criterion to apply is consistency. In analyzing the interview transcripts, I thought carefully about whether patterns were consistent across different cases. To be credible, the final report should show that the researcher checked out ideas and responses comprehensively (Rubin and Rubin 1995). When seemingly contradictory information surfaced, I looked for clarifications.

Trueness is about giving the reader "confidence that the factual materials asserted are accurate" (Lofland and Lofland 1984: 150). As Rubin and Rubin recommend (1995:87), I have made extensive use of quotations to provide support for each finding. Admittedly, I made mistakes in my first interview by asking questions that inhibited the respondent from speaking her own mind (Maxwell, 1996: 90). In subsequent interviews, however, I asked questions that would allow the respondent to speak in a voice based on personal experience (Glesne 1999: 73). Qualitative researchers endeavour to provide "a

full and revealing picture of what is going on” (Maxwell, 1996:95). I believe I have captured, in a modest way, some of the complexities of emotion management in hospital chaplaincy.

Communicability is the final criterion. It means that the story resonates with readers (Rubin and Rubin, 1995: 91; Strauss and Corbin, 1990:23). I have tried to make the writing alive and engaging by filling it with vivid illustrations.

Limitations and Directions for Future Research

Qualitative analysis is more likely to result in the construction of walls than the creation of palaces (Dey 1993: 52). As Patton puts it: “there are no perfect research designs. There are always trade-offs” (2001: 162). Due to the exploratory character of this investigation, I often deviated from the interview guide. More importantly, I was probably too ambitious and naive in thinking that obtaining ethics clearance from healthcare institutions in Toronto would be a reasonable task. Far from that, it can be very time and labour-intensive, exhausting most resources available to any graduate student not already affiliated with a hospital, and challenging to a researcher’s commitment to fieldwork.

As a limitation, it should be noted that even though the small sample of 21 respondents allowed for greater depth and more meaningful interaction with respondents, the findings of my study cannot be generalized to all chaplains who work in Canada. Also, the sample is likely to be biased in terms of gender, as I was unable to interview more than three male chaplains, in contrast to 18 females.

I was unable to collect data on Hochschild's distinction between surface and deep acting. Also, while I found evidence of chaplains concealing emotions, I did not uncover any examples of chaplains attempting to fake absent feelings. This is perhaps because such distinctions (surface acting vs. deep acting, evoking absent emotions vs. suppressing present emotions) are not very common among chaplains; maybe it is unethical for them to fake emotions in order to perform their job. It is also possible that I failed to design questions that would explore this area. Similarly, while I elaborated on the concept of emotional dissonance in my research findings, I was unable to find concrete examples of failure in emotion management, or an unwillingness to perform it that would have allowed me to discuss emotional deviance.

Much of what has been learned here could be further studied with a larger, more representative investigation into the emotional experiences of hospital chaplains. It would be interesting to look at the theological aspects of hospital chaplaincy and the potential complication that may arise in chaplains' religious ideas as a result of dealing with pain and suffering. I was primarily concerned with the emotional side of chaplaincy, and focussed less on the theological one. Future studies should consider how chaplains' own faith and theology is influenced as a result of working with troubled people. For example, how can witnessing unjustified pain and suffering impact chaplains' own faith? How are they able to maintain their religiosity if they see injustices in the natural distribution of health? In which ways are chaplains' faith bolstered or shaken? How would they deal with people who have superficial ideas about religion or even are hostile towards it?

It would be also instructive to study the emotion management of chaplains with regard to other medical and healthcare professionals (e.g. social workers, nurses, etc.) for

a comparison of the complexities, challenges, similarities as well as differences in emotion management among different categories of healthcare professionals.

Implications of Research

Given its empirical emphasis, my hope is that this study would first and foremost benefit the chaplains whom I interviewed. I hope it provides a better and more refreshing understanding of their job and the different aspects of it. My desire is that by incorporating a variety of accounts, from different chaplains in different situations and in different institutions, I have provided a rich analysis of emotion management, its nuances and its complications. Individual chaplains should be able to benefit from the various strategies of emotion management employed by their colleagues. The significance of hospital chaplaincy as a profession should be also emphasized because of the support and services they offer to people. In the first chapter, I argued that in order to provide a strong and efficient service, the health and emotional well-being of healthcare providers should be considered first. My research showed that full-time chaplains are likely to suffer from job pressures. This could, in turn, affect not only their personal lives, but also their job performance. Heads of chaplaincy departments, clinical directors, and other administrative personnel in the hierarchy of the healthcare system should therefore pay specific attention to these consequences.

In addition to chaplains and healthcare policy makers, sociologists and researchers of emotion may also find this study interesting as an application of symbolic interactionist, phenomenological, and ethnomethodological approaches to a rather

unexplored area. At the end of her research report on grief work among women experiencing perinatal loss, Davidson names three future research goals:

I would like to further my research in three ways. First, expanding on my core concept of griefwork, I would like to situate the dying person in her or his own griefwork, as labour shared and negotiated with intimates and caregivers. Second, as I was intrigued by the social-emotional and instrumental labour of hospital chaplains in the development of the bereavement protocols, I would like to further study the work of the chaplaincy in hospital, in their support of patients, families and caregivers. And third, I would like to further develop what I have described as the repositioning of caregivers between high technology and patients (Davidson 2008: 215).

My study can be described as an investigation in what Davidson calls “the social-emotional and instrumental labour of hospital chaplains” (2008: 215). Although its focus is primarily on emotional aspects, my study can also help to explain how chaplains offer their services socially and instrumentally as well. I have made the case that hospital chaplaincy is emotionally rich. Chaplains experience a wide range of different emotions. However, it can be challenging if chaplains do not take care of themselves properly. I hope the results of this study contribute not only to the existing literature on the sociology of emotions in healthcare and emotional labour, but also to the profession of chaplaincy whose primary responsibility is to be with people at times of difficulty and crisis.

References

- Almarza (2008) "When a Parent Has Cancer: An Examination of the Lived Experience of Adult Children Living at Home." M.A., Simon Fraser University (Canada), Dissertation Abstract International; AAT MR46855.
- Ara Allene, F. (2008) "Bearing Imperfect Children: Raising Kids with Problems in an Era of Anxiety and Medicalization." Ph.D., University of California, Davis, *Dissertation Abstract International*: AAT 3336249.
- Baker, P. S., William, and Clair, M. (2003) "Emotional Expression during Medical Encounters: Social Disease and the Medical Gaze." In James V. and Gabe J. (Eds.) *Health and the Sociology of Emotions*, Oxford: Blackwell: 173-200.
- Barbalet, J. M. (2001) *Emotion, Social Theory, and Social Structure: A Macro Sociological Approach*. Cambridge: Cambridge University Press.
- Beck, U. (1992) *Risk Society: Towards a New Modernity*, Translated by Mark Ritter. London: Sage Publications.
- Bell, B. J. (2003) "The Rites of Passage and Outdoor Education: Critical Concerns for Effective Programming." *The Journal of Experiential Education*, 26 (1): 41-50.
- Bendelow, G. and Williams, S. (Eds.) (1997) *Emotions in Social Life: Critical Themes and Contemporary Issues*. NY: Routledge.
- Blumer, H. (1972) "Action vs. Interaction." *Society*, 9: 50-53.
- Bolton, S. (2000) "Who Cares? Offering Emotion Work as a 'Gift' in the Nursing Labour Process." *Journal of Advanced Nursing*, 32: 580-6.
- Bolton, S. (2001) "Changing Faces: Nurses as Emotional Jugglers." *Sociology of Health and Illness*, 23: 85-100.
- Bolton, S.C., Boyd, C. (2003) "Trolley Dolly or Skilled Emotion Manager? Moving on from Hochschild's Managed Heart." *Work, Employment and Society*, 17(2): 289-308.
- Bowser, B. P., and Seiber, J. B. (1993) "AIDS prevention Research: Old Problems and New Solutions." In Renzetti, C. M. and Lee, R. M., (Eds.) (1993) *Researching Sensitive Topics*, Newbury Park, CA: Sage Publications: 160-176.

- Brewer, J. D., (1993) "Sensitivity as a Problem in Field Research: A Study of Routine Policing in Northern Ireland," in Renzetti, C. M. and Lee, R. M., (Eds.) *Researching Sensitive Topics*, Newbury Park, CA: Sage Publications: 125-145.
- Cadge, W. (2009) "Religion, Spirituality, and Health: An Institutional Approach. In Clarke, P., B. (Ed.) (2009) *The Oxford Handbook of the Sociology of Religion*, Oxford: Oxford University Press: 836-856.
- Cadge, W., et al. (2008) "Hospital Chaplaincy in the United States: A National Overview." *Southern Medical Journal*, 101(6):626-630.
- Carrillo J. E., et al. (1999) "Cross-Cultural Primary Care: A Patient-based Approach." *Annals of Internal Medicine*, 130:829-834.
- Cicourel, A. (1973) *Cognitive Sociology: Language and Meaning in Social Interaction*. Penguin Books Ltd. Middlesex: UK.
- Charon, R. (2001) "The Patient-Physician Relationship, Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust." *Journal of American Medical Association*, 286:1897-1902.
- Clark, C. (1987), "Sympathy Biography and Sympathy Margin." *American Journal of Sociology*, 93 (2): 290-321.
- Clark, P. B. (Ed) (2009) *The Oxford Handbook of the Sociology of Religion*. Oxford: Oxford University Press.
- Clarke, J. N., (2000) *Health, Illness, and Medicine in Canada*. 3rd Ed. Don Mills, Ont.: Oxford University Press.
- Collins, R. (1981), "On the Micro Foundations of Macrosociology." *American Journal of Sociology*, 86 (5): 984-1014.
- Copp, M. (1998), "When Emotion Work is Doomed to Fail: Ideological and Structural Constraints on Emotion Management." *Symbolic Interaction*, 21 (3): 299-328.
- Craddock Lee, S. J. (2002) "In a Secular Spirit: Strategies of Clinical Pastoral Education." *Health Care Analysis*, 10:339-356.
- Crossley K. (2002) "Professional Satisfaction among U.S. Healthcare Chaplains." *The Journal of Pastoral Care & Counseling*, 56 (1): 21-29.
- Davidson, D. A. (2007) "The Emergence of Hospital Protocols for Perinatal Loss, 1950-2000," Ph.D., York University (Canada), *Dissertation Abstract International*, AAT NR39000

- DeCoster, V. A. (1997) "Physician Treatment of Patient Emotions: An Application of the Sociology of Emotion." In Erickson R. J., and Cuthbertson-Johnson, B. (Eds.) *Social Perspectives on Emotion* (Vol. 4), NY: JAI Press. 151-78.
- Denzin, N. (1984) *On Understanding Emotion*, San Francisco: Jossey-Bass.
- Denzin, N. (1983) "A Note on Emotionality, Self and Interaction," *American Journal of Sociology*, 89 (2): 402-409.
- Denzin, N. (1985) "Emotion as Lived Experience," *Symbolic Interaction*, 8 (2): 223-240.
- Denzin, N. and Lincoln Y. (Eds.) (2000) *The Handbook of Qualitative Research*. Second Edition. Newbury Park, CA, Sage.
- Dewe, P. J. (1987) "New Zealand Ministers of Religion: Identifying Sources of Stress and Coping Strategies." *Work and Stress*, 1(4): 351-363.
- Dey, I. (1993) *Qualitative Data Analysis: A User Friendly Guide for Social Scientists*. NY: Routledge.
- DiLalla, L. F., et al. (2004) "Empathy, Acceptance of Spirituality, and Wellness in Medicine: A Cross-Sectional Study." *Teaching and Learning in Medicine*, 16: 165-70.
- Doka, K. (1989) *Disenfranchised Grief: Recognising Hidden Sorrow*. Lexington, MA: Lexington books.
- Douglas, J. D., (1985) *Creative Interviewing*, Beverly Hills, CA: Sage.
- Ducharme, L. J., et al. (2008) "Emotional Exhaustion and Turnover in Human Service Occupations: the Protective Role of Coworkers Support." *Sociological Spectrum*, 28: 81-104.
- Eder, D. and Parker, S. (1987) "The Cultural Production and Reproduction of Gender: The Effect of Extracurricular Activities on Peer Group Culture." *Sociology of Education*, 60(3): 200-213.
- Emke, I. (2002) "Why the Sad Face? Secularization and the Changing Function of Funerals in Newfoundland," *Mortality*, 7 (3): 269-284.
- Erickson R. J. and Grove J. C. (2008) "Emotional Labor and Health Care." *Sociology Compass* 2 (2): 704-733.

- Figley, C. R., (1995) "Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview," in Figley, C., R. (Ed.), (1995) *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*, NY: Brunner/Mazel psychological stress series, No. 23: 1-20.
- Fischer, A. (2000), *Gender and Emotion: Social Psychological Perspectives*, Cambridge [England]: Cambridge University Press.
- Flannelly, K. J., et al. (2004) "Factor Affecting Healthcare Chaplaincy and the Provision of Pastoral Care in the United States." *The Journal of Pastoral Care and Counseling*, 58: 127-130.
- Flannelly K. J., et al. (2005a) "A National Survey of Health Care Administrators' Views on the Importance of Various Chaplain Roles." *The Journal of Pastoral Care and Counseling*, 59: 87-96.
- Flannelly K. J., et al. (2005b) "Correlates of Compassion Fatigue and Burnout in Chaplains and Other Clergy who Responded to the September 11th Attacks in New York City." *The Journal of Pastoral Care & Counseling*, 59: 213-224.
- Fox, J. (2006) "Notice How You Feel: An Alternative to Detached Concern among Hospice Volunteers." *Qualitative Health Research*, 16: 944-61.
- Francis E., L. (2006) "Emotions and Health." In Turner, J. and Stets, J. (Eds.) (2006) *Handbook of the Sociology of Emotions*. NY: Springer. 591-610.
- Francis, L, Kathleen M, and Berger, C., (1999). "A Laughing Matter? The Uses of Humor in Medical Interactions." *Motivation and Emotion*, 23: 155-174.
- Freund, P. E. (1990) "The Expressive Body: A Common Ground for the Sociology of Emotions and Health and Illness." *Sociology of Health and Illness*, 12: 452-477.
- Freund, P. E. (1997) "Social Performances and their Discontents: The Biopsychosocial Aspects of Dramaturgical Stress." In Bendelow, G. and Williams, S.J. (Eds.) (1997), *Emotions in Social Life: Critical Themes and Contemporary Issues*. NY: Routledge. 268-294.
- Gabe, J., et al. (2004) *Key Concepts in Medical Sociology*. London: Sage Publications.
- Gary D. et al (1988) "Burnout among Licensed Psychologists." *Professional Psychology: Research and Practice*, 19 (6): 624-631.
- Gibbons, J. L., and Miller, S.L. (1989) "An Image of Contemporary Hospital Chaplaincy." *The Journal of Pastoral Care*, 43(4): 355-363.

- Glaser, B. and Strauss, A. (1967) *The Discovery of Grounded Theory*. Chicago: Aldine.
- Glesne, C. (1999) *Becoming Qualitative Researcher: An Introduction*. Second Edition. NY: Addison Wesley Longman, Inc.
- Goffman, E. (1959) *The Presentation of Self in Everyday Life*. NY: Doubleday Anchor.
- Goffman, E. (1961) *Encounters: Two Studies in the Sociology of Interaction*. Indianapolis: Bobbs-Merrill.
- Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall, Inc.
- Gordon J. S. (1982) "Holistic Medicine: Advances and Shortcomings." *Western Journal of Medicine*, 136:546-551.
- Gordon, S., L. (1981) "The Sociology of Sentiments and Emotions." In Rosenberg M. and Turner R., H (1981) (Eds.) *Social Psychology: Sociological Perspectives*. New York. Basic Books. 261-278.
- Gordon, S., L. (1986). "Micro-sociological Theories of Emotion." In Eisenstadt, S.N and Helle H., J. (1986) (Eds.) *Micro-Sociological Theory: Perspectives on Sociological Theory*, Vol. 2: 133-147.
- Green, L. and Grant, V. (2008) "Gagged Grief and Beleaguered Bereavements? An Analysis of Multidisciplinary Theory and Research Relating to Same Sex Partnership Bereavement." *Sexualities*, 11 (3): 275-300.
- Greer, K. (2002) "Walking an Emotional Tightrope: Managing Emotions in a Women's Prison." *Symbolic Interaction*: 25 (1) 117-139.
- Gross, F., W. (2009) "A Phenomenological Study of Experiences in Coping with Critical Events by Urban First Responders in a Metropolitan Area," Ph.D., Loyola University Chicago, Dissertation Abstract International; AAT 3367108.
- Haggerty K. D. (2004) "Ethics Creep: Governing Social Science Research in the Name of Ethics." *Qualitative Sociology*, 27(4):391-414.
- Halpern, J. (2001) *From Detached Concern to Empathy: Humanizing Medical Practice*. Oxford, NY: Oxford University Press

- Heritage, J., and Maynard, D. (2006) "Problems and Prospects in the Study of Physical-Patient Interaction: 30 years of Research." *Annual Review of Sociology*, 32:351-374.
- Hochschild, A. (1979) "Emotion Work, Feeling Rules and Social Structure." *American Journal of Sociology*, 85 (3): 551-75.
- Hochschild, A. (1983) *The Managed Heart: Commercialization of Human Feelings*. Berkeley: University of California Press.
- Hochschild, A. (1997) "The Sociology of Emotion as a Way of Seeing." In Bendelow, G. and Williams, S.J. (Eds.) (1997) *Emotions in Social Life: Critical Themes and Contemporary Issues*. NY: Routledge. 3-15.
- Hochschild, A. (2003) *The Commercialization of Intimate Life: Notes from Home and Work*. Berkeley: University of California Press.
- Homans, C. G. (1961) *Social Behavior: Its Elementary Forms*. NY: Harcourt, Brace and World.
- Horwitz, A. V. (2007) "Transforming Normality into Pathology: The 'DSM' and the Outcomes of Stressful Social Arrangements." *Journal of Health and Social Behavior*, 48 (3): 211-222.
- Jaggar, A. (1989) "Love and Knowledge: Emotion in Feminist Epistemology." In Jaggar A. and Bordo S.R. (Eds.) (1989) *Gender/Body/Knowledge: Feminist Reconstructions of Being and Knowing*, New Brunswick, NJ: Rutgers University Press. 145-71.
- James, V. and Gabe, J. (2003) *Health and the Sociology of Emotions*, Oxford: Blackwell.
- James N. (1989) "Emotional Labor: Skill and Work in the Social Regulation of Feelings." *Sociological Review*, 37 (1): 15-42.
- Kemper, T. (1990) *Research Agenda in the Sociology of Emotions*. Albany, NY: SUNY Press.
- Kemper, T. (1978) *A Social Interactional Theory of Emotions*, NY: Wiley.
- Kemper, T. (1981) "Social Constructivist and Positivist Approaches to the Sociology of Emotions." *American Journal of Sociology*, 87 (3): 336-61.
- Kemper, T. (1987) "How Many Emotions Are There? Wedding the Social and the Autonomic Components." *American Journal of Sociology*, 93 (2): 263-89.

- Kenney, J. S. (2010) *Canadian Victims of Crime: Critical Insights*. Toronto. Canadian Scholars' Press.
- Knafl, K. A. and Webster, D.C. (1988) "Managing and Analyzing Qualitative Data: A Description of Tasks, Techniques and Materials." *Western Journal of Nursing Research*, 10(2): 195-218.
- Koenig, H. G., et al. (1998) "Religious Coping and Health Status in Medically Hospitalized Older Adults," *Journal of Nervous and Mental Disease*, 186 (9): 513-521.
- Konradi, M. A. (1991) "Preparing to Testify: Rape Survivors Negotiating the Criminal Justice Process." *Gender and Society*, 10(4): 404-432.
- Laine, C. and Davidoff, F. (1999) "Patient-Centered Medicine: A Professional Evolution." *Journal of American Medical Association*, 275:152-156.
- Lawler, E., J. and Thye, S. R. (1999) "Bringing Emotions into Social Exchange Theory." *Annual Review of Sociology*, 25: 217-244.
- Lee, R. M., (1993) *Doing Research on Sensitive Topics*, Newbury Park, CA: Sage Publications.
- Lincoln, Y. S. and Guba, E. G. (1985) *Naturalistic Inquiry*, Beverly Hills, CA: Sage Publications.
- Lively, K. J. (2006) "Emotions in the Workplace." In Turner, J. and Stets, J. (Eds.) (2006) *Handbook of the Sociology of Emotions*. NY: Springer. 569-590.
- Lively, K. J. (2000) "Reciprocal Emotion Management: Working together to Maintain Stratification in Private Law Firms." *Work and Occupations*, 21: 32-63.
- Lofland, J. and Lofland, L. (1995) *Analysing Social Settings: A Guide to Qualitative Observation and Analysis*. Belmont, CA: Wadsworth.
- Lofland, J. (1976) *Doing Social Life: the Qualitative Study of Human Interaction in Natural Settings*, NY: Wiley.
- Lynch, J. J. (1977) *The Broken Heart: The Medical Consequences of Loneliness*. NY: Basic Books.
- Madjar, I. (1998) *Giving Comfort and Inflicting Pain*. Walnut Creek, CA: Left Coast Press.

- Mann, S. (2004) "People Work: Emotion Management, Stress and Coping." *British Journal of Guidance and Counselling*, 32: 205-21.
- Maslach, C. and Jackson, S., E. (1986) *The Maslach Burnout Inventory*. Palo Alto, CA: Consulting Psychological Press (2nd edition).
- Maxwell, J. A. (1996) *Qualitative Research Design: An Interactive Approach*. Applied Social Research Methods Series, Vol. 41. Thousand Oaks, CA: Sage.
- May, W.F. (1983) *The Physician's Covenant: Images of the Healer in Medical Ethics*, Philadelphia: The Westminster Press.
- Marrazzo, J. (2008) "Gender Considerations in the Phenomenon of Transgenerational Grief," M.S.W., University of Wyoming, Dissertation Abstract International; AAT 1465154.
- Mears A., and Finlay, W. (2005) "Not Just a Paper Doll: How Models Manage Bodily Capital and Why They Perform Emotional Labor." *Journal of Contemporary Ethnography*, 34(3): 317-343.
- Miles, M. B. and Huberman, M. A. (1994) *Qualitative Data Analysis: An Expanded Sourcebook*. Thousand Oaks: Sage.
- O'Connor J. T., et al. (2005) "Not Well Known, Used Little and Needed: Canadian Chaplains' Experiences of Published Spiritual Assessment Tools," *Journal of Pastoral Care & Counseling*, 59(1/2): 97-108.
- O'Connor J. T., and Meakes, E. (2008) "Canadian Ethnographic Study of Sources and Definitions of Theological Reflections in Pastoral Care and Counseling." *Pastoral Care and Counseling*, 62 (1/2):113-126.
- O'Neil, P. (2002) "Good Intentions and Awkward Outcomes: Ethical Gatekeeping in Field Research." In Van den Hoonaard, W. (Ed.) (2002) *Walking the Tightrope: Ethical Issues for Qualitative Researchers*, Toronto: University of Toronto Press. 17-25.
- Pargament, K., et al. (2000) "The Many Methods of Religious Coping: Development and Initial Validation of RCOPE." *Journal of Clinical Psychology*, 56(4): 519-543.
- Patton, M. (2001) *Qualitative Research & Evaluation Methods*. Thousand Oaks, CA: Sage.
- Pearlman, L., A. (1999) "Self-care for Trauma Therapists." In Figley, C., R. (Ed.), (1995) *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder*

in *Those Who Treat the Traumatized*, NY: Brunner/Mazel Psychological Stress Series, No. 23.

- Peterson, G. (2006) "Cultural Theory and Emotions." In Turner, J. and Stets, J. (Eds.) (2006) *Handbook of the Sociology of Emotions*. NY: Springer. 114-134.
- Rafaeli, A. and Sutton, R. (1987) "Expression of Emotion as Part of the Work Role." *Academy of Management Review*, 12: 23-37.
- Rayburn, C. A., et al. (1986) "Men, Women and Religion: Stress within Leadership Roles." *Journal of Clinical Psychology*, 42(3): 540-546.
- Rubin, H J. and Rubin I., S. (2005) *Qualitative Interviewing: The Art of Hearing Data*. Thousand Oaks, CA: Sage.
- Sandelowski, M. (2000) "Focus on Research Methods: Whatever Happened to Qualitative Description?" *Research in Nursing & Health*, 23:334-340.
- Schnell, J., A. (2003) *Case Studies in Culture and Communication: A Group Perspective*, Lanham, MD: Lexington Books.
- Schweingruber D., and Berns N. (2005) "Shaping the Selves of Young Salespeople through Emotion Management." *Journal of Contemporary Ethnography*, 34 (6): 679-706.
- Seery, B. L. (1997) *Four Types of Mothering Emotion Work: Distress Management, Ego Work, Relationship Management, and Pleasure/Enjoyment Work*. Dissertation Abstracts International, The Humanities and Social Sciences, 57(8): 3699.
- Sharma, U. and Black, P. (2001) "Look Good, Feel Better: Beauty Therapy as Emotional Labour." *Sociology*, 35:913-31.
- Siegel, K. and Weinstein, L. (1983) "Anticipatory Grief Reconsidered." *Journal of Psychological Oncology*, 1(2): 61-73.
- Smith P. (1992) *The Emotional Labour of Nursing*. London: Macmillan.
- Smith, A, and Kleinman S., (1989) "Managing Emotions in Medical School: Students' Contacts with the Living and the Dead." *Social Psychology Quarterly*, 52: 56-69.
- Snyder, E. E. and Aamons (1993) "Baseball's Emotion Work: Getting Psyched to Play." *Qualitative Sociology*, 16(2): 111-132.

- Spencer-Carver, E. (2008) "Social Support for Children Who Had a Parent Killed by Intimate Partner Violence: Interviews with Mental Health Workers," Ph.D., Kansas State University, *Dissertation Abstract International*; AAT 3310830.
- Stamm, B., H. (1999) "Introduction to the Second Edition." In Figley, C., R. (Ed.), (1995) *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*, NY: Brunner/Mazel psychological stress series, No. 23.
- Stokes, A. (1985) *Ministry After Freud*, NY: The Pilgrim Press.
- Strauss, A. and Corbin, J. (1990) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*, Newbury Park, CA: Sage.
- Thoits, A. P. (1990) "The Sociology of Emotions." *Annual Review of Sociology*, 15: 317-42.
- Thoits, A. P. (1990) "Emotional Deviance: Research Agendas," In Kemper, T (Ed.) (1990) *Research Agenda in the Sociology of Emotions*. Albany, NY: SUNY Press. 180-206.
- Thoits, A. P. (1996) "Managing the Emotions of Others." *Symbolic Interaction*. 19 (2): 85-109.
- Turner, J. (1999) "Toward A General Sociological Theory of Emotions." *Journal for the Theory of Social Behaviour*, 29 (2): 133-62.
- Turner, J and Stets, J. (2006) *Handbook of the Sociology of Emotions*, NY: Springer.
- Turner, J. and Stets, J (2006) "Sociological Theories of Human Emotions." *Annual Review of Sociology*, 32: 25-52.
- Taylor, E. B., et al. (2006) "Compassion Fatigue and Burnout among Rabbis Working as Chaplains." *Journal of Pastoral Care and Counselling*, 60 (1/2): 35-42.
- Taylor, R. J., et al. (2000) "Mental Health Services in Faith Communities: The Role of Clergy in Black Churches." *Social Work*, 45(1): 73- 87.
- VandeCreek L. and Burton L. (2001) "Professional Chaplaincy: Its Role and Importance in Healthcare." *The Journal of Pastoral Care*, 55 (1): 81-97.
- Van den Hoonaard, W. (Ed.) *Walking the Tightrope: Ethical Issues for Qualitative Researchers*. Toronto: University of Toronto Press.

- Vieira, J. F. (1990) "Reflections of a Hospital Chaplain." *Journal of Health Care Chaplaincy*, 3 (1):105-106.
- Warner J. and Carter, J. D. (1984) "Loneliness, Marital Adjustment and Burnout in Pastors and Lay Persons." *Journal of Psychology and Theology*, 12(2): 125-131.
- Weaver, A. J., et al. (2004) "A Review of Research on Chaplains and Community-Based Clergy in the Journal of the American Medical Association, Lancet, and the New England Journal of Medicine: 1998-200." *The Journal of Pastoral Care and Counseling*, 58: 189-201.
- Weaver, A. J., et al. (2002) "Mental Health Issues Among Clergy and Other Religious Professionals: A Review of Research," *The Journal of Pastoral Care & Counseling*, 56 (4):293-403.
- Weiler, C (1975) "Patients Evaluate Pastoral Care." *Hospital Progress*, 56 (4): 34-38.
- Weiss, R. S., (1994) *Learning from Strangers: The Art and Method of Qualitative Interview Studies*. NY: The Free Press.
- Wengraf, T. (2001) *Qualitative Research Interviewing: Biographic Narrative and Semi-structured Methods*. Thousand Oaks, CA: Sage Publications.
- Wharton, A., S. (1993) "The affective consequences of service work: Managing emotions on the job." *Work and Occupations*, 20:205-32.
- Wharton, A., S. (2009) "The Sociology of Emotional Labor." *Annual Review of Sociology*, 35: 147-65.
- Wouters, C. (1989) "The Sociology of Emotions and Flight Attendants: Hochschild's Managed Heart." *Theory, Culture and Society*, 6(1): 95-123.
- Wright, M. C. (2000) "Chaplaincy in Hospice and Hospital: Findings from a Survey in England and Wales." *Palliative Medicine*, 15: 229-242.
- Zurcher, L. (1982) "The Staging of Emotion: A Dramaturgical Analysis," *Symbolic Interaction*, 5 (1): 1-22.

Appendix

CONSENT FORM FOR CHAPLAINS

Research Project Title: Emotion Management in Hospital Chaplaincy

Researcher: Masoud Kianpour, under the supervisions of Dr. Stephen Riggins and Dr. Scott Kenney, Memorial University of Newfoundland (MUN)

This consent form, a copy of which will be left with you for your records and reference, is part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research (such as the way you have been treated or your rights as a participant), you may contact the ICEHR Chairperson at icehr@mun.ca or by telephone at 709-737-8368. If you would like more detail about anything mentioned here, or information not included here, you should feel free to ask. Please take the time to read carefully this statement and any accompanying information.

I, _____, understand that this interview is being conducted as a Ph.D. thesis at MUN. I understand that the sole researcher is Masoud Kianpour, a PhD Candidate at MUN, and that I will be interviewed by him. He can be reached at 416-921-8106 or through e-mail at mkianpour@mun.ca. The supervisors for this project are Dr. Scott Kenney, who can be reached at 709-737-8047 or through e-mail at skenney@mun.ca, and Dr. Stephen Riggins, who can be reached at sriggins@mun.ca. The Head of the sociology department is Dr. Anthony Micucci, who can be reached at amicucci@mun.ca. I understand the focus of this interview will be the emotional management of chaplains working in Toronto hospitals. I understand I will be asked questions regarding my emotional experiences, my reactions to patients' conditions, my perceptions about the emotional difficulties of my job, and if I have experienced any emotional turmoil while working. **I am aware that I may find some of the topics discussed in the interview upsetting and that I may experience some emotional discomfort. However, I understand that the interviewer can provide me with referral information if I would like to have emotional support as a consequence of this interview. I am also aware that I do not have to answer all questions; and at any time I may stop the interview, briefly speak off the record, and then continue the interview. It has been explained to me that a total of twenty-five people will be interviewed for this study.**

I understand that I will participate in an interview that will last approximately one hour. I understand that with my permission the interview will be audio-recorded and later transcribed. I am aware that the audiotapes will only be accessed by the researcher. I am also aware that the audiotapes and transcripts will not have my name or any other identifying information on them. A research code number will be used instead. All data will be kept on a secure computer which will be password protected. Access to the computer will be secured by the use of specific passwords known only to the researcher. I understand that the completed interview schedules, transcriptions, audiotapes and other research data will be stored in a secure, locked cabinet and that all such research data will be destroyed in 2015. Memorial University requires the retention of data for a minimum of five years in case of challenges to the results of the study.

Any questions I have asked about this study have been answered to my satisfaction. I recognize that the researcher may in the future publish or make presentations based on this research. However, I have been assured that no information will be released or printed that would disclose my personal identity or jeopardize my employment. I have been assured that my responses will be completely confidential. Any risks or benefits that might arise out of my participation have also been explained to my satisfaction. I understand that my participation is voluntary and that my decision either to participate or not to participate will be kept confidential. I further understand that I can withdraw from this study at any time without explanation and without negative consequences. I hereby consent to participate in this study.

Date: _____ Participant: _____



