Title:

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Session Title:
Health of the Nursing Workforce
Slot:
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2:35 PM

Keywords:
Emotional Labor, Hospice and Nursing Workplace

References:


Abstract Summary:
We present two dynamics among nurses and supervisors in Hospice Interdisciplinary Group Meetings: Supervisors encouraging nurses to process their emotional labor with patients and in contrast, supervisors suppressing these attempts and imposing what we describe as secondary emotional labor. We discuss implications of these dynamics for nurses, patients and organizations.

Learning Activity:

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<tr>
<th>LEARNING OBJECTIVES</th>
<th>EXPANDED CONTENT OUTLINE</th>
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<td>The learner will be able to explain the difference between emotional labor, a necessary and valuable nursing skill, and secondary emotional labor, a negative experience most associated with care of highly vulnerable patients.</td>
<td>1) Presentation and definitions of emotional labor and secondary emotional labor 2) Literature review of state of the concept emotional labor 3) The relevance for nursing</td>
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<td>The learner will be able to apply the concepts emotional labor and secondary emotional labor to their own work settings and analyze their implementation in relation to these concepts.</td>
<td>4) Qualitative data that shows and analyzes the concepts 5) Rationale for development of a new concept (secondary emotional labor) 6) Implications for nursing in clinical settings and future research</td>
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Abstract Text:
PURPOSE: Emotional labor is the process by which one suppresses one’s true feelings and countenance to bring about a desired state of mind in patient/client. Although it has been studied for decades, we still know little about how supervisor/supervisee interactions with nurses shape whether patient oriented emotional labor is experienced as positive or negative. (Hochschild, 2003; Hülsheger & Schewe, 2011). Patient oriented emotional labor can support high quality care which is the goal of health care organizations, however, denying workers the opportunity to process client oriented emotional labor with supervisors to get feedback to improve their performance can undermine the organization’s goal. When a worker attempts to discuss their client related emotional labor and a supervisor denies the opportunity and withdraws support, it can create a second level of suppression which we term secondary emotional labor. We have created a new concept to highlight the importance of emotional labor for nursing to underscore the negative consequences when health care organizations fail to support this essential occupational activity. To explore how supervisors encourage or suppress nurses’ attempts to process their emotional labor with patients, we conducted an ethnographic study of nurses and their supervisors in a hospice setting over a period of several years.

BACKGROUND: For professionals such as nurses successful emotional labor encounters with patients can be highly rewarding but ironically, they can also be risky in the absence of supervisory support to process these episodes (Grandey, Diefendorff, & Rupp, 2013; Humphrey, Ashforth, & Diefendorff, 2015; Theodosius, 2008). The nursing literature suggests that nurses who work with the most vulnerable patients, such as infants in the neonatal intensive care unit or palliative care and hospice patients, may be at high risk of negative outcomes when they are denied the opportunity to process their emotional labor experiences (Cricco-Lizza, 2014; Theodosius, 2008). Processing emotional labor with high risk clients is linked to emotional reinforcement and the development of skills that are essential for professionals such as hospice nurses (Liebenberg, 2011). To explore how supervisors encourage or suppress hospice nurses’ attempts to process their emotional labor with patients, we conducted an ethnographic study of a hospice setting over a period of several years. The first author attended weekly Interdisciplinary Group (IDG) meetings to analyze the interactions among hospice nurses and supervisors as nurses attempted to discuss their emotional labor with patients during the meetings.
RESEARCH DESIGN: This was a qualitative ethnographic study of a community hospice program nested in a division of homecare that is part of a 369 bed general medical surgical hospital in an upper middle income suburb in the Tri-State area. An interdisciplinary team approach to patient care is provided in the home, in assisted living facilities, and in nursing homes. IDG meetings included from 10 to 14 people, representing all disciplines, and usually occurred from 8:30 AM to 11:00 AM every Wednesday. Each patient’s care plan is reviewed every 15 days and updated to assess patient status, progress, and Medicare/Medicaid eligibility. The study is supported by the IRB at both the hospital where the study is being conducted and at the first author’s home institution.

DATA COLLECTION AND ANALYSIS: The data comes from an on-going ethnographic study of a hospice setting during which various data collection methods were employed over a period of 3 years, from June 2012 to January 2016. The first author was the sole data collector and she attended 40 IDG meetings staying for their entirety and took jottings that were immediately transcribed into full length field notes at the meeting’s conclusion. She conducted 20 interviews with nurses and their supervisors over this period. The grand tour interview question which was followed by probes to encourage depth descriptions of events and experiences was, “Tell me about your experiences working in hospice.” Interviewees were mostly nurses and their supervisors. Interviews lasted from 1 to 4 hours and were transcribed verbatim by a transcription service. IDG meetings included from 10 to 14 people, representing all disciplines. Field notes and interview transcripts were analyzed using inductive theory building through content analysis (Krippendorff, 2012). To begin, the first author read through all the field-notes and interview transcripts to identify and label codes, some of which, when categorized, emerged as two opposing processes or interactions that were occurring in IDG meetings. Both authors then reviewed the literature and, based on their understanding of emotional labor, identified two sets of interactions in which nurses discussed their emotional labor.

RESULTS: The two sets of interactions included one in which nurses successfully discussed their emotional labor in the context of IDG meetings and another in which they were discouraged or impeded by supervisors from doing so in a way that we describe as secondary emotional labor. The tension between these two dynamics is partly rooted in the contrast between the latent function of IDG meetings for emotional labor processing and skill building, and their official purpose to review and update patient plans, document collaborative efforts, and determine patients’ eligibility for hospice, this eligibility being tied to the agency being reimbursed for services rendered (Fine, Davis, & Muir, 2014). Our data analysis shows the positive dynamics of IDG meetings when supervisors encourage discussion of emotional labor by 1) by providing opportunities for individuals to share their emotional labor experience, to receive empathy, and to be acknowledged for their effort, and 2) by advising workers as they seek to hone their emotional labor skills. We then show how secondary emotional labor is imposed with the implication for negative outcomes.

IMPLICATIONS: We argue that processing emotional labor with supervisors promotes the strengths and skills of nurses and should be encouraged for their sake, their patients, and the organization. The fact that hospice nursing requires the nursing staff to engage in intense emotional labor, and that the organization benefits from these efforts are compelling reasons for integrating support of emotional labor at the organizational level (Duke, Goodman, Treadway, & Breland, 2009). Research that points to the importance of supervisors, specifically the role they play in mediating the challenges faced by nurses who work with the most vulnerable and difficult patients provides a way to understand how to protect nurses and other health care providers in a variety of health care occupations. Organizations can either reinforce the insidious dynamics of secondary emotional labor or support the emotional labor that is a central component of what makes patient care and health care organizations successful.