DELICIOUS AMBIGUITY? ORGANIZATIONAL, INTERPERSONAL, AND PERSONAL COMMUNICATION ABOUT SPIRITUALITY AT HOSPICE

A Dissertation

by

JENNIFER ROBIN CONSIDINE

Submitted to the Office of Graduate Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

August 2006

Major Subject: Speech Communication

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Approved by:

Chair of Committee,	Katherine Miller
Committee Members,	James Aune
	Carolyn Clark
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ABSTRACT

Delicious Ambiguity? Organizational, Interpersonal, and
Personal Communication about Spirituality at Hospice. (August 2006)
Jennifer Robin Considine, B.A., Marquette University;
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Chair of Advisory Committee: Dr. Katherine Miller

While a great deal of theoretical work affirms the importance of spirituality in hospice care, the manner in which organizational members communicate about spirituality in hospice organizations, and most other health care organizations, remains under-explored and under-theorized. The purpose of this dissertation is twofold. First, this dissertation seeks to understand how hospice members talk about spirituality with one another and with care recipients. Second, this dissertation explores the antecedents and consequences of hospice members' communication strategies.

To explore these issues, an ethnographic study was conducted in two branches of a mid-sized hospice. Over 200 hours of participant observation and 42 interviews were completed. Results showed that organizational discourse about spirituality was strategically ambiguous in response to multiple internal and external demands. Strategically ambiguous communication was successful in allowing for a wide range of actions and interpretations; however, it was also problematic in that it served as a source of discomfort and disconnection for some organizational members.

Further, results demonstrated that communication about spirituality in

interactions between care providers and care recipients was influenced by both organizational discourse and personal understandings of spirituality. Organizational and professional discourse and personal understandings created dialectical tensions between leading and following in care provider-care recipient interactions. Further analysis demonstrated five different strategies for managing the leading-following dialectic.

Finally, results suggested that organizational discourses affected the personal identity and outcomes experienced by hospice workers. The preferred organizational identity of the “Gracious Servant” required hospice workers to perform spiritual labor which increased the care providers’ propensity to experience stress and burnout. In total, these results demonstrate the importance of examining spirituality from an ecological perspective that considers community, organizational, and interpersonal discourse about spirituality.

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I am especially grateful to my family who has supported me throughout my graduate education. The love of my parents and siblings has given me the courage to pursue my dream of being a professor. I am so thankful that you all come to visit me and share in my life, no matter how far away from home I wander. Your support encourages me to ask important questions and pursue a life without limits.

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CHAPTER I

INTRODUCTION AND REVIEW OF LITERATURE

In the hospice palliative care unit, Jasmine Claude was dying of cancer. The cancer filled her abdomen so completely that she appeared to be almost nine months pregnant. The pressure from the tumor made breathing difficult and lying comfortably impossible. Doctors knew death was imminent and urged Mrs. Claude to see to her final affairs. Despite all of these difficulties, Mrs. Claude felt at peace. When interviewed by researchers collecting the stories of hospice patients, she stated, “No matter what happens, I know that God is there for me. I often wonder why this had to happen to me, of all people. I don’t know what it all means. But I can look death squarely in the eye. Don’t get me wrong; I do feel angry and frustrated about all this, but I won’t allow it to get me down” (Towers, 2000, p. 291). To the moment of her death, Mrs. Claude’s faith brought her a sense of serenity and peace.

For her caregivers, however, Mrs. Claude’s faith brought curiosity, fascination, skepticism, inspiration, and confusion. In her rendition of Mrs. Claude’s story, Towers (2000) tells of a myriad of reactions from hospice caregivers. Many of her nurses, particularly those with a strong faith of their own, reported being inspired by such unshakeable faith in the mystery of death. In contrast, several physicians reported curiosity, skepticism and suspicion. Towers writes, “On the one hand they assumed, tacitly, that religion isn’t adequate. They took the psychodynamic view of religion that is

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This dissertation follows the style of *Management Communication Quarterly*.

often taught in medical school and saw faith as a maladaptation, even as pathological. At the same time, however, they could not deny, and even admired the enormous power of what they had witnessed, a power that called into question the narrowness of their skeptical psychological interpretations" (p. 304). Although physicians outwardly affirmed Mrs. Claude's faith in their interactions with her, inwardly her faith challenged their technical, scientific approach to death, and to life.

This narrative and a multitude of others (see for example Baird & Rosenbaum, 2003; Barnard, Towers, Boston & Lambrinidou, 2000; Mason, 2002) affirm the centrality and mystery of spirituality in hospice care. Yet the nature and practice of spirituality in hospice organizations -- as in most other health care organizations -- remains under-explored and undertheorized, particularly in the communication discipline. In a recent special issue of *Health Communication*, Parrott (2004) notes, "Despite widespread collections of evidence regarding relations between religious faith and health, literature regarding the study of religious faith and spirituality in health communication is sparse to none. Within the field of communication more broadly, publications relating to religion and faith are also few" (p. 2). This lack of research seems particularly unfortunate given the potential for a wide variety of communication scholarship to illuminate several issues pertaining to spirituality in hospice care. Even in this brief excerpt of Mrs. Claude's story, we see the potential to draw on several communication approaches. For example, communication literature regarding role conflict might help to explain physicians' ambivalence as they seek to resolve their professional scientific and technical socialization with personal issues of faith. Extant

research on doctor patient communication might suggest ways for physicians' to deal with Mrs. Claude's faith in their discussions with her regarding care decisions. Research on the intersection of home and work life could illuminate the inspiration other caregivers received from Mrs. Claude's approach to her impending death.

As the hospice movement continues to expand in the United States, with almost a million patients and their families served by hospices in 2004 alone (Hospice Facts and Figures, 2004), it seems critical that we use our knowledge of communication to illuminate and explore the challenges of spirituality within hospice care. This dissertation will draw upon existing communication theory and literature along with an ethnographic study of two locations of a mid-sized hospice, to explore and theorize the role of spirituality within hospice organizations. In addition, I will explore the interplay of this organizational understanding of spirituality with three other issues: (1) communication with patients, families and other care providers, (2) care providers' personal spiritual understandings, and (3) care providers' spiritual motivation, coping and levels of stress and burnout.

In this chapter, I begin by articulating a communication approach to the understanding and study of spirituality at hospice. Once this theoretical approach is established, I will review existing literature to establish the current knowledge base with respect to the role of spirituality within hospice care. Drawing from this theoretical approach and literature review, several research questions are then posed. In the following chapter, I will explain the methods employed to collect and analyze data relevant to these research questions. Chapters III, IV, and V will consider the results of

the research, considering issues of spirituality within the organizational and community context, spirituality as enacted in interaction between care providers and care recipients, and the influence of spirituality on the personal identity and outcomes of hospice workers. The final chapter of the dissertation will discuss these findings in terms of current theory in the areas of communication and spirituality and consider directions for future research.

Theorizing and Exploring Spirituality

Before entering the discussion of the role of spirituality within hospice care, it is essential that we have some mutual understandings about spirituality, both what it is and how it can be accessed in the research process. These are by no means simple questions. In many ways, spirituality is an individual level, subjective phenomenon that resists examination by traditional scientific means. Not only is spirituality difficult to study, it is also resistant to definition. Indeed, operationalizations of spirituality have been vague and contradictory in much of the academic literature (Egbert, Mickley, & Coeling, 2004; Koenig, McCullough, & Larson, 2001). In addition, ethical concerns abound when researchers examine spiritual issues, especially when religion and spirituality are causally linked to outcomes such as improved health and well-being (Koenig, 2002) or organizational performance (Giacolone & Jurkiewicz, 2003). Even as these challenges offer important cautions, these difficulties should not turn communication researchers away from exploring spiritual issues. In fact, it may be precisely these difficulties that necessitate a communication oriented approach to the study of spirituality within hospice care.

Terms, Definitions, and Underlying Assumptions

For the purposes of this dissertation, spirituality will be defined as "the actions and interactions of an embodied human actor who is facing death and creating a personally meaningful social world, a constructed world that can be either a resource or an encumbrance" (Daaleman & VandeCreek, 2000, p. 2516). This definition has several key elements that necessitate further explication; however, before I begin this discussion, it is important to explain my selection of the term "spirituality" as opposed to "religion" to capture this broad process of meaning making.

It is only in the last few decades that "spirituality" seems to have overtaken "religion" as the preferred term for capturing human experiences of the numinous. For example, in contemporary hospice literature, spirituality and religion are usually differentiated, and spiritual is often the preferred term. In a recent article targeted toward medical practitioners, Daaleman and VandeCreek (2000) suggest that religion includes "the totality of belief system, an inner piety or disposition, an abstract system of ideas, and ritual practices" (p. 2514). These authors suggest that spirituality is a somewhat broader concept that may or may not involve religious practices, beliefs or communities. Daaleman and VandeCreek's dissociation between spirituality and religion seems driven by an admirable purpose. They suggest that physicians, particularly those working in end of life care, should be concerned about their patients' search for personal meaning because it can directly influence patient quality of life. However, in a multicultural world in which traditional religions are no longer the sole sources of meaning (Bradshaw, 1996), Daaleman and VandeCreek recognize that some other term must be used to

capture this more diverse array of meaning making systems. Hence, hospices are adopting the term “spirituality.” It is to meet these inclusive goals that I also adopt the term spirituality in this dissertation.

I must note that this dissociation between religion and spirituality is in no way an attempt to valorize one and demonize the other, as has sometimes been the case in the workplace spirituality literature. For example, consider the writings of Ian Mitroff, a workplace spirituality scholar who seems determined to create a complete separation between religion and spirituality. Mitroff (2003) writes, "Religion is seen as dividing people through dogma and its emphasis on formal structure. It is viewed as intolerant, closed-minded, and excluding all those who do not believe in a particular point of view. Spirituality, on the other hand, is viewed as both personal and universal. It is perceived to be tolerant, open-minded, and potentially including everyone" (p. 377). This comment illustrates the potential dangers of creating clear lines of demarcation between religion and spirituality. Mitroff’s strict dichotomizing of the terms does not allow for the possibility that religion could be a positive, uniting force in the world. For purposes of this dissertation, then, I use spirituality as an umbrella term to capture the socially constructed process in which hospice patients, family members, and employees find meaning, meaning which may or may not come through religious belief.

We turn next to further explication of the definition of spirituality. Two major assumptions need to be clarified. I begin by discussing the need for meaning making and then turn to the examination of the socially constructed process through which meaning is found. The search for meaning is a fundamental preoccupation of human experience.

Berger (1967) argues, “Man, biologically denied the ordering mechanisms with which the other animals are endowed, is compelled to impose his own order upon experience.” Eisenberg (2001) adds, “Coping with the uncertainties of one’s positionality in the world is key to ontological security, which is another name for emotional or mental health” (p. 585). Thus, the search for meaning is of fundamental importance to the human experience. We turn now to the manner in which individuals make meaning of life experiences.

Individuals do not locate meaning apart from their positioning in society. As the definition of spirituality states, individuals are “embodied” actors living in “constructed” worlds. Thus the outside world plays a fundamental role in individual constructions of meaning. The notion that individual action is affected by larger societal discourses is supported by Foucault’s work on discourse and power. In his understanding of discourse, Foucault (1977) examines how truth is historically, culturally, and socially constructed through discourse and how these discursive notions of truth create and reify certain power structures. As individuals act within these discourses, certain types of knowledge are privileged and others marginalized. He argues that discourses provide both rules for acting and potential for resistance. Drawing upon this postmodern approach to discourse, Mumby (2001) writes, “Discourses are thus texts and communicative practices that function within (and reproduce) certain ‘truth games’ (rules for what counts as true and false), defining the subject and submitting him or her to the processes of normalization” (p. 606). In modern society, religious meaning systems form one “discourse” which compete with many other “discourses” in

suggesting the appropriate answer to questions of ontological uncertainty (McGuire, 2002). Because religious discourses still play a very prominent role in society, we turn next to exploring the role of religion in meaning construction at both the individual and societal levels.

The search for meaning is both an individual and a societal preoccupation. Berger (1967) argues that human beings construct a social world in which a meaningful order is bestowed upon their experiences. Religion, he argues, is the "human enterprise" by which this social order becomes elevated to a cosmic, sacred level (p. 25). Religion, then, serves as a template for interpreting experiences and assigning meaning (Berger, 1967; Geertz, 1966). Of particular importance for this study is the fact that religion often becomes especially important as individuals are facing their own death or the death of their loved ones because death threatens the fundamental assumptions of order in society (Berger, 1967). To counter this threat of chaos, societies create theodicies, religious explanations for meaning-threatening experiences. For example, death may be less threatening when one interprets that death is preordained by God and has some larger meaning that we may not understand. Simply the belief that God is in control can create order in an otherwise chaotic experience. Religion becomes an especially powerful ordering experience because it suggests that the social order is more than just a human creation (Berger, 1967).

Despite the power of these socially constructed religions, the fact remains that religion is constructed by human beings who have the power to both reify and resist religious rules (Berger, 1967; Giddens, 1984). As individuals function within a particular

society, they learn the norms and values of the prevailing meaning system. During this process of socialization, individuals may internalize the meaning system offered by society or they may reject or modify meanings offered to them. This negotiation between individuals and discourses is explained by structuration theory which argues that "the reproduction of social systems lies in the routinized, day-to-day interactions of agents in their use of rules and resources" (Kirby & Krone, 2002, p. 55). Within structuration theory, the rules and resources articulated by societal discourse are termed "structures" and seen as "recipes" for acting (Giddens, 1984; Kirby & Krone, 2002; Poole, Seibold, & McPhee, 1996). Individuals appropriate these rules in a variety of fashions and their adaptation or resistance to these rules can change the social system. It is this process which may explain the wide variety of spiritualities existing in America today. As people move away from traditional faith communities and experience a wider variety of spiritual traditions, they are borrowing elements from many different religious traditions in order to create their own individual spirituality.

Individual spiritual experiences may range considerably in both content and effect. In a classic study of religious experience, William James (1902) found that individual religious experiences come in mystical and nonmystical forms. Religious experiences may be pleasurable, creating feelings of peace, joy, and optimism. They may also be frightening, provoking feelings of anxiety and loneliness. James suggests that the manner in which individuals understand their religious faith can influence their health and wholesomeness, their capacity to withstand the strains of life, their willingness to change, and their ability to encounter difficulties with optimism rather

than pessimism. Later studies of religious experience have also found a wide range of content and outcomes of religious experience (Fowler, 1981; Peck, 1987). The fact that religion and consequently spirituality can have both positive and negative effects underscores the need for further study of the role of spirituality in hospice care.

In summary, spirituality is the term used to refer to individual's meaning making processes. For the purposes of this study, meaning making process that relate to death and dying are of special importance. Two key assumptions are crucial to this study. First, spirituality is understood as both a societal and an individual phenomenon. Individuals have personal spiritual experiences, but these experiences are both enabled and constrained by the socially constructed meaning systems within which individuals operate. Second, individual's personal spiritualities may have both positive and negative consequences for their physical and psychological well-being. This definition of spirituality has profound implications for the manner in which we must approach the study of spirituality and I turn next to these more practical questions. The key question we must answer is: how are we to negotiate between multiple levels of analysis, between the global and the local, and between religious and nonreligious understandings of spirituality?

A Discursive Ecological Approach

In this study, I attempt to meet these challenges by taking an ecological perspective which explores the interrelationship between care providers and care recipients as situated at the nexus of a diverse array of organizational and societal discourses. In advocating such an approach, Street (2003) argues that "communication in

[healthcare] interactions is (or can be) affected by the interpersonal, organizational, media, political-legal and cultural environments within which they take place" (p. 64). This approach encourages us to look at spirituality at several different levels.

First, care providers and care recipients may each have particular spiritual understandings which influence the provision of care. Second, organizations may have particular ways of talking about spirituality that suggest the appropriate manner for understanding and managing spiritual issues. Both individual and organizational discourse about spirituality may be affected by societal discourses. These discourses may be particularly important as this study is being conducted in a time in which the appropriate role of spirituality is a subject commonly debated in politics and the media. By tacking between societal discourses about the role of spirituality in hospice care and the actual day to day practices of hospice care providers, we can gain a greater understanding of the challenges of incorporating spirituality into hospice care. In the next section, I review the history of spirituality in hospice care to preview some of the challenges and contradictions that may be faced by hospice workers in their provision of spiritual care.

Spirituality and Hospice

In the last three decades, the hospice movement in America has grown dramatically. The aging of the baby boom generation, the increasing prevalence of chronic disease, and the decreased reliance on family members as the sole providers of care for the aging, have generated a need for teams and organizations designed to provide care for the terminally ill. The National Hospice and Palliative Care

Organization estimates that approximately 3,300 hospices are operating in the United States serving almost a million patients and their families each year (Hospice Facts, 2004).

Although hospice care is relatively new to America, the concept of hospice has ancient roots. The word “hospice” comes from the Latin word “hospis,” meaning host and guest (Siebold, 1992) and for many years was used to refer to any place that provided shelter to those in need. In mid-nineteenth century France, Madame Gamier associated the “term” hospice specifically with care for the terminally ill when she used it as the moniker for the institution she established to provide care for the dying (Hospice Education Institute, 2006). Over the next two centuries, homes for the dying all over Europe were given the name hospice. Although hospice care in America is more often provided in patients’ homes than in a separate institution, the guiding principle that the hospice patient is to be treated as an honored guest remains central to the hospice philosophy.

Wherever hospice care is provided, the hospice philosophy remains the same - the provision of holistic, palliative care. The World Health Organization (WHO) defines palliative care as: “The active total care of patients whose disease is not responsive to curative treatment...control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount” (1990, p. 11). Mackay and Sparling (2000) identify six basic principles of palliative care based on WHO guidelines: (1) affirming life and viewing death as a natural process; (2) neither hastening nor postponing death; (3) providing relief from distressing symptoms and pain; (4) integrating spiritual and

psychological aspects of care giving; (5) offering a support structure to assist patients in living as actively as possible until death; and (6) offering a support system that helps families cope during the patient's illness and their bereavement (p. 460).

As articulated in these fundamental principles, spiritual care is an integral aspect of palliative care. Many trace the centrality of spiritual care in palliation to the work of Cecily Saunders, the founder of the modern hospice movement. In the 1960s, Saunders and colleagues joined together in forming St. Christopher's Hospice in the United Kingdom. Saunders believed that only a Christian foundation would attract and sustain the vocation of hospice staff; hence, St. Christopher's philosophy was firmly rooted in Western Christian tradition (Bradshaw, 1996). Although St. Christopher's certainly works with people of all faith traditions - and those with no faith tradition - its mission remains firmly rooted in Christian ethics. The organization's vision statement articulates this commitment:

> St. Christopher's Hospice is a religious foundation, based on the full Christian faith in God, through Christ. Its aim is to express the love of God to all who come, in every possible way; in skilled nursing and medical care, in the use of every scientific means of relieving suffering and distress, in understanding personal sympathy, with respect for the dignity of each patient as a human being, precious to God and man. It is planned that the staff should form a community, united by a strong sense of vocation with a great diversity of outlook in a spirit of freedom. (Saunders, 1986, p. 5)

This Christian understanding had a profound impact upon the early understanding of

spiritual care within modern hospices. Due to the monotheistic nature of Christian tradition, spirituality was originally defined in terms of a relationship with God or a Divine Other (Bradshaw, 1996). Hence, practices of care included daily ward prayers and chapel visits (Saunders, 1986). However, these traditional practices are changing.

Spirituality: The Shifting Terrain

As articulated in the opening of this paper, contemporary definitions of spirituality have expanded beyond this monotheistic vision, leading to what some consider a more caring hospice ideal and some just a more confusing one. An understanding of spirituality as a sense of meaning and connection has replaced a God-centered theological understanding (Bradshaw, 1996; McGrath, 1997). We turn next to the potential consequences of such a shift.

Certainly there are potentially significant benefits to the movement away from a Christian understanding of spiritual care. It might be argued that an expanded definition of spirituality would be more inclusive in contemporary pluralistic America and there are those who celebrate this spiritual inclusiveness. Cultural and religious differences have a profound influence on attitudes toward death and dying and religious traditions often include rules and norms for managing end-of-life care (Daaleman & VandeCreek, 2000). A shift away from a Christian ethic of spiritual care allows for more flexibility in responding to this variety of needs.

Some researchers have suggested that this shift toward inclusivity mirrors a larger American cultural shift from a concern for traditional religious faith to a "spirituality of seeking" (Daaleman & VandeCreek, 2000, p. 2516). Bradshaw (1996)

extends this argument, suggesting that God has become the “ultimate taboo” in America leading to a marginalization of religious talk (p. 413). Indeed, Eric Wilkes of the National Hospice Council argues that the Christian foundation for hospice work “is already attenuated in a society not embarrassed by sex or death now, but ultimately ill at ease at any mention of God or spiritual distress” (1993, p. 4). Hence, we might see this new understanding of spirituality as an attempt to create space for spiritual discussion in a society that is increasingly uncomfortable with words such as God, faith, and religion.

However, this shifting understanding of spirituality is not without potentially significant and devastating costs. First among these costs is the possibility of an impending hopelessness in the face of death. Bradshaw (1996) argues, “If the objective truth claims of religion are relegated in favour of a definition of the spiritual as an anthropocentric and nebulous ‘search for meaning,’ then it needs to be admitted that the way is open for the individuals concerned, patients and family alike, to find no meaning” (p. 417). Secondly, Bradshaw suggests that the shift away from a firm ethical foundation rooted in the Christian value for life may leave open the possibility for a “new attitude of care” that cannot be “condemned for withholding treatment and mercy killing” (p.417). There is no doubt that the issues of euthanasia and physician assisted suicide present profound ethical dilemmas for hospice workers and the shifting away from a concrete and totalizing ethical value system allows for new dialogue, debate, and understanding of these ethical issues.

Spirituality: Shifting to the Sidelines

As the definition of spirituality has been shifting within the hospice movement,

the role of spirituality in hospice care has also shifted. Whereas spirituality in the sense of Christian ethics and understandings was once the bedrock of hospice philosophy and decision making, the new, more nebulous, understanding of spirituality is unable to provide such a firm basis and has thus created space for new discourses to become the primary foundation of hospice identity and decision making. Next, I explore other discourses that are vying with the spirituality discourse for prominence within hospice organizing.

James and Field (1992) suggest that when the charismatic leadership and spiritual focus of the original founders dissipates, the hospice tradition becomes vulnerable to the processes of bureaucratization and routinization. McGrath's (1997) analysis of the most influential discourses in a modern hospice demonstrates the power of new discourses in hospice care. Using a postmodern discursive approach, McGrath uncovers four primary discourses vying for priority in a contemporary hospice: (1) the hospice discourse, (2) the Buddhist discourse, (3) the spiritual discourse, and (4) Western biomedical discourse. She argues that the spiritual discourse is a space for resistance against the more powerful biomedical discourse. However, this labeling of spiritual discourse as a "space for resistance" further indicates the power of the technological imperative of Western biomedical discourse.

The power of western biomedical and technological discourses has so challenged the centrality of spiritual care that many see this discourse as the new bedrock of hospice. Like McGrath, Bradshaw (1996) argues that traditional moral and spiritual values of hospice are being challenged as new areas have emerged and taken precedence

in defining the work of hospice. One challenge comes from the medicalization of pain treatment. Where once medicine was seen as one tool for dealing with pain, it has now become the primary tool. Of particular significance for the role of spiritual care is the introduction of medication for anxiety and depression which is often prescribed for patients in pain. Whereas this pain was once treated as potentially caused by a spiritual problem and necessitating a spiritual solution, now this pain is often treated with a simple pill rather than a more comprehensive intervention involving physical, psychological, and spiritual care (Bradshaw, 1996).

This tendency for the prioritization of medical over psychological or spiritual interventions is further exacerbated by the move toward research and auditing of hospices. The need to establish a sense of professionalism, to gain accreditation in order to receive government funding, and the pressures to conform to insurance company standards have made hospices increasingly subject to auditing and evaluation (McGrath, 1997). Scholars argue that these audits will tend to focus on the more easily measurable indicators of treatment such as drugs used, physical interventions and patients served (James & Field, 1972). This focus leaves behind the more difficult to observe and operationalize interventions involving effective communication, expressions of empathy, discussions of feelings, satisfaction, spirituality, and well-being. As these interventions go unmeasured and thus under supported and under financed, they are likely to be subsumed under the pressures to meet more measurable audit goals. For example, American hospices are required to provide spiritual care to receive Medicaid funding; however, no federal funds or guidelines for offering this care are provided (Moore,

personal communication, September 9, 2004).

In sum, we see the hospice movement as existing at the center of competing and shifting discourses. The Christian spiritual foundation of hospice, which once provided a firm ethical and philosophical framework, is in danger of being pushed aside. Although this shift may provide space for a more inclusive approach to spiritual care, there is also the risk that hospice will re-center upon the bedrock of modern medical technology and government funding, potentially marginalizing spiritual care completely.

There are costs and benefits to building on either the biomedical or spiritual discourse. As suggested by the earlier discussion of the power of discourse, the biomedical and spiritual discourses suggest different rules for the content and processes of communication at the organizational level including the structure of organizing and decision making processes, as well as the content and processes of communication at the interpersonal level among staff as well as between patients and care providers. The more obvious choice may be for a hospice to prioritize either spiritual discourses or biomedical/bureaucratic discourses, choosing one of these as the foundation for their organizational identity and practices.

However, it is also possible that an organization will find a way to live in the contradictions and paradoxes of these two discourses without privileging one or the other. Precedent for such an endeavor can be found in Ashcraft's (2001) work on organizational dissonance in which organizations embrace the "strategic, ironic union of antagonistic elements" thus allowing them to accomplish potentially paradoxical goals (p. 1301). Openness to the possibility of strategic incongruity and creativity seems

especially important in a study that examines the potentially paradoxical requirements of blending medical and spiritual care and multiple spiritual perspectives. As Ashcraft (2001) argues, if we want to enable productive social change, we need to reject the notion of heroes versus villains and consider the possibility of blending philosophies, even those presumed oppositional. Hence, this research seeks to explore how hospice employees and teams experience and resolve the potentially contradictory demands of the spiritual, religious, and biomedical/bureaucratic discourses as they develop an organizational philosophy of spiritual care. The following research questions are posited:

RQ1: What is the discourse of spirituality at hospice?

RQ2: How does this discourse interact with other prominent discourses within hospice organizing (particularly biomedical, religious, and bureaucratic discourses)?

RQ3: How do teams and individuals at hospice experience and manage the contradictory demands of these discourses?

Spirituality Discourses and Patient Provider Communication

Certainly, any understanding of the power of discourse is incomplete with only a focus on the organizational responses to such contradictions. There must also be a corresponding focus on organizational practice and individual responses to these contradictions. It must be remembered that the contradictions posed by the competing discourses at hospice challenge individuals as well as the organizations within which they function. Ashcraft (2001) notes that organizations that are struggling to resolve contradictory discourses face difficulties. She claims, “Certainly, fine lines divide

strategic incongruity, delusions of unfettered agency, and crippling binds. Additional research is needed to determine which dialectical tensions are more critical or immobilizing and if, when, how and why alternative practices might mitigate bureaucratic excess" (p.1317). These immobilizing influences might be particularly prominent in cases of individual decision making. We turn next to an exploration of the challenges and contradictions faced at the interpersonal and intrapersonal levels as care providers and recipients negotiate their own spiritual subjectivity and draw upon these understandings in their interactions with one another.

Care Recipient Spirituality

Just as hospices are struggling to negotiate and articulate understanding in the midst of swirling discourses about spirituality, patients may find themselves doing the same. For care recipients, spirituality discourses may be a source of comfort, distress, and/or confusion. Significant evidence exists that spiritual meaning-making has a central role in understanding death and dying (Keeley, 2004). Religious and spiritual beliefs may be a source of great strength and social support for individuals facing terminal illness and their families. In a study of final conversations between dying patients and their family members, Keeley (2004) found that 87 % of participants mentioned issues related to religion and spirituality in their final conversations with loved ones. These final conversations about spirituality often served to validate beliefs and provide comfort to both parties.

Religious and spiritual beliefs may also influence the acceptance of certain interventions of care, particularly within the medical arena. A recent study found that

45% of outpatients interviewed at the University of Pennsylvania Hospital had religious beliefs that would influence their medical decisions if they became seriously ill (Ehman, Ott, Short, Ciampa, & Hansen-Faschen, 1999). For example, religious beliefs may influence compliance with treatments such as blood transfusions and end-of-life decision making (Koenig, 2002). Different religions may articulate different methods for dealing with end-of-life issues, both those faced immediately before death and immediately after (Bodell & Weng, 2000). Even in non-medical interventions, religious beliefs may dictate what types of care are acceptable to a patient. For instance, some more fundamentalist Christians express a deep distrust of social workers and mental health professionals which keeps them from seeking or desiring help from these professional caregivers (Canda & Furman, 1999).

Despite the positive impact of religion and spirituality for many patients, there is significant evidence that others may find religious beliefs to be unimportant or a source of great discomfort and even harm. Just as religion and spirituality have historically been used to help, they have also been a source of hatred, aggression, prejudice, and pain. For example, Higdon (1986) found that the fundamentalist or Pentecostal religious worldview was frequently affiliated with the presentation of dissociative or compulsive disorders. Bowman (1989) also found that some religious worldviews lead individuals to equate emotional difficulties with sin or spiritual weakness in such a manner that they begin to feel intense shame and self-inflict or accept repeated physical, spiritual, sexual, or emotional abuse. The potentially negative consequences of spirituality and religion may be particularly prominent for individuals facing terminal illness. In interviews with

12 patients facing cancer, McGrath (2002) found that “spiritual pain” often accompanied such diagnoses as patients experienced a sense of meaninglessness just as they sought to make sense of difficult and painful treatments. A follow up study with hospice patients found that there was little evidence that serious illness led to religious conversion (McGrath, 2003). In fact, patients facing terminal illness were just as likely to see religion as unimportant or actively turn away from religion as they were to experience a strengthened religiosity in the face of the illness.

These conflicting interpretations of the role of spirituality place hospice workers in a very challenging situation. On a daily basis, they may have to deal with patients with a variety of spiritual needs. Some patients may be devout, others uncaring, and still others experiencing spiritual pain or anger. In addition to these different attitudes toward religion and spirituality, patients are likely to have a variety of spiritual belief systems from those based in traditional religions such as Christianity, Islam, Judaism, or Hinduism to those based in New Age or 12-step spiritualities. To further complicate an already difficult situation, hospice workers are called upon to serve not only those facing terminal illness, but their families as well. In some cases, families may have homogenous spiritual beliefs, but in others there may be a multitude of spiritual understandings and consequently different expectations for appropriate medical, psychological and spiritual interventions.

Previous studies note a strong feeling of confusion on the part of hospice workers faced with these complexities. Many studies have shown that health care professionals are hesitant or uncomfortable discussing spiritual or religious issues (Millison & Dudley,

1992). There is also confusion about whose job includes the provision of spiritual care (West & West, 2003). Does spiritual care belong only in the province of the chaplain or are social workers, nurses, administrators and doctors also involved in the provision of spiritual care? Even when all hospice workers accept the job of spiritual care, they are often uncomfortable determining appropriate care interventions. For example, in interviews with 62 hospice social workers, Wesley, Tunney and Duncan (2004) were told stories about perplexing or confusing experiences of providing spiritual care from over half of the interviewees. Social workers felt inadequate and unprepared to deal with spiritual issues, particularly with patients and families whose spiritual traditions were different from their own.

In locating the source for this confusion, it is important to examine how care providers may be socialized to deal with spiritual issues at work. Certainly, the organizational discourse regarding spiritual care can play a profound role as care providers determine appropriate spiritual care interventions. However, it is unlikely that the organizational discourse is the only discourse that contributes to such decisions. Care providers are also likely to be influenced by their own spiritual and religious perspectives. We turn next to an exploration of care provider spirituality.

Care Provider Spirituality

In a recent study of nineteen care providers, Considine (2004) found four different orientations toward spirituality in the workplace: inclusive spirituality, exclusive spirituality, conflicted spirituality, and spirituality as separate from care. These four orientations suggested very different rules for appropriate spiritual interventions

with care recipients. For example, those with an exclusive spiritual orientation were more likely to proselytize or pray with patients and view spirituality from their own perspective. Those who viewed spirituality as separate avoided spiritual discussions or referred patients to clergy or chaplains. Finally, those who had a more inclusive or conflicted approach to spirituality were likely to view spirituality from the patient's perspective and thus were very careful to use qualifiers and offer their ideas with tentativeness when engaging spiritual issues. These caregivers used questions and other screening processes at the beginning and during discussions to be sure that any discussion of spiritual issues was comfortable for the client.

Considine's (2004) study also showed that professional socialization could influence beliefs about appropriate spiritual care interventions. Although some medical schools and social work programs are beginning to explore the role of spiritual care, many care providers are educated in programs that continue to ignore the spiritual part of care (Koenig, 2002; Wesley, Tunney, & Duncan, 2004). Wesley and colleagues found that over half of 62 social workers surveyed would like further education regarding assessment of spiritual issues, assisting with spiritual rituals and discussion of spiritual issues in extraordinary care, suicide, euthanasia and assisted suicide. Because spiritual care is often marginalized in professional socialization, care providers may begin to assume that it is "unprofessional" to engage such topics. This role conflict is particularly apparent in the narrative of one social worker in the Wesley, Tunney and Duncan study. The social worker writes, "Although social workers have usually not received any training in the area of spirituality and traditionally have been instructed not to 'go there,'

we do our clients a disservice if we cannot address these issues as they arise. As hospice workers, we in fact have to understand the patient's spiritual landscape, for without this knowledge and the ability to integrate the spiritual with the psychological, our interventions will be less effective" (p. 44). Thus, in addition to the confusion encountered in dealing with care recipient's spiritual diversity, care providers must also negotiate their own role conflict stemming from potentially contradictory organizational, professional, and personal beliefs about spiritual care.

Obviously the spiritual landscape in hospice care is likely to be confusing for care providers as it is littered with potentially contradictory expectations and interpretations. In order to understand how care providers communicate care in the face of such challenges, it is necessary to explore the micro practices of spiritual care. By focusing on this localized discourse, this study aims to understand how hospice care providers understand and negotiate the confusing expectations of the complicated discursive landscape within which they operate. The following research question is posited:

RQ4: What do hospice workers say when discussing spirituality with patients, families and co-workers?

In their communication with others, hospice workers not only draw upon previous discourse, they also create new discourse which may follow previously established rules or create new avenues for thinking and acting about spirituality with clients. This communication reflects the aforementioned process of structuration which examines permanence and change within organizations (Giddens, 1984). In order to

complete our understanding of the relationship between discourse and action in the organizational setting, we must examine the effect of individual action and interpersonal communication upon organizational discourse. The following research question is posited:

RQ5: How does the spiritual communication of hospice workers reify and resist organizational discourse regarding spiritual care?

Outcomes of Spiritual Communication

Finally, it is important to examine the outcome of such policies for care provider well-being. Of particular concern for hospices are high turnover rates and burnout among care providers. Certainly, the emotional burden of dealing with death and dying on a daily basis can be exhausting and spiritually and psychologically challenging. Faced with patients' and clients' stories of trauma, care providers may begin to question their core faith in a process often referred to as "vicarious traumatization." Pearlman and Saakvitne (1995) argue, "We have come to believe over time that the most malignant aspect of vicarious traumatization is the loss of a sense of meaning for one's life, a loss of hope and idealism, a loss of connection with others, and a devaluing of awareness of one's experience…best described as spirituality" (p. 160).

Further extending the possibility of burnout is the role conflict stemming from competing organizational and societal discourses. As previous research suggests role conflict and role ambiguity are leading causes of burnout (Miller & Ellis, 1990); it is important to explore further the roots of this conflict and potential management strategies. In order to avoid negative outcomes of managing trauma, caregivers may

perform “spiritual work” to maintain emotional and physical health (Boyle & Healy, 2003; Koenig, 2002; Pearlman & Saakvitne, 1995; Sass, 2000). Boyle and Healy (2003) found that paramedics might use new age practices such as meditation or counseling sessions with ministers in order to regain spiritual and emotional health. Sass (2000) reported that nursing home caregivers went to the chapel to pray when working with patients gets too upsetting or annoying. Hence, one way that care providers may make sense of the trauma of death and dying is to work within one primary spiritual discourse borrowing from its structures to determine their actions.

Such a process was evident in Considine’s (2004) study in which individuals who did not report conflict regarding spirituality at work positioned themselves largely within one particular discourse and engaged in the activities suggested by that discourse. Such a positioning allowed these individuals to avoid the potentially negative personal effects of role conflict and provided individuals with significant motivation to provide care in the most difficult of circumstances. However, this exclusive definition of spirituality created potential conflicts between care providers and care recipients as well as among care providers with different spiritual orientations.

In contrast, individuals who articulated a conflicted spirituality approach expressed significant stress over the incorporation of spirituality at work because they could not find a discourse in which to position themselves that met both their needs and the needs of the care recipient. They would engage in actions primarily under a more inclusive spirituality discourse, but they would often judge these actions within an exclusive spirituality discourse which resulted in significant dissonance and often guilt

and shame. Such an approach may have been beneficial for care recipients but often came at a significant cost for care providers. Hence, it is important to examine the outcomes of organizational policies upon individual care provider's motivation and burnout level. The final research question is posed:

RQ 6: How does the structuration of spiritual care policies affect care provider motivation, coping mechanisms, and the experience of stress and burnout?

In summary, this opening chapter has demonstrated that spirituality had an important historical role in palliative care; however, the increasing bureaucratization and medicalization of hospices are threatening to push spiritual discourse aside in favor of biomedical, technological discourse (James & Field, 1992; McGrath, 1997). In addition, the growth of religious pluralism in American society has forced a reexamination of the Christian conceptualization of spirituality that guided early hospices. Thus, hospice providers that want to maintain a commitment to traditional, holistic, palliative care are being forced to find new ways to talk about spirituality and new ways to appropriately account for religious pluralism in providing spiritual care. This dissertation adopts an ecological perspective to explore communication about spirituality in one particular hospice setting and to examine how care providers respond to the challenges created by competing discourses about spirituality and medicine. In the next chapter, I outline the procedures used in this study, describe the organizational context, and introduce the study participants.

CHAPTER II

RESEARCH METHODOLOGY

In order to explore communication and spirituality in hospice care, I conducted a five-month ethnographic study at Central County Hospice (CCH).[1] In this chapter, I begin by discussing and defending the use of ethnographic methods for this study. Next, I detail the data collection procedures, describe the organizational context, and provide information about research participants. Third, the methods and tools for data analysis are explained. Finally, I reflect upon the impact of my own worldview, actions, and goals upon both the process and outcomes of this research.

Methodological Choices

In any study, the choice of methodology is often presented as a strategic response to theoretical concerns. In this study, the choice of methodology is a response to theoretical concerns, but it is also a somewhat arbitrary choice based upon the needs and desires of this researcher. As Taylor and Trujillo (2001) explain, "Qualitative methods seem to choose researchers. We refer here to the sense of fulfillment experienced by many researchers as they discover in qualitative methods a resonant 'permission' that enables them to work through in their research the contraditions and ambiguities created in their personal histories and professional socializations" (p. 179). Certainly, my choices of both method and organizational setting were in part guided by the belief that CCH was an environment in which I could question and discuss the contradictions and tensions experienced when incorporating spirituality into the workplace.

[1] In order to protect the anonymity of the participants, pseudonyms are provided for all participants, organizations, and cities.

My first encounter with the culture and employees at CCH came nearly nine months before this project was initiated. At that time, I was conducting interviews for a study on communication and spirituality in the helping professions. Snowball sampling led me to CCH, and I conducted interviews with four CCH staff. In these interviews, the CCH staff members were open to my questions and their high levels of self-reflexivity were evident as they narrated dozens of stories about spirituality at CCH. These interviews suggested that spiritual care was central to the work of CCH, and perhaps even more important for this study, that at least some CCH staff members recognized and reflected upon many tensions of combining spirituality and work and were willing to discuss and share these tensions with an outsider like myself. As a researcher and a spiritual seeker, I found myself drawn to an organization and a set of employees who would engage these issues so directly and my initial dream of performing an ethnographic study at CCH was born. As I continued to plan this study and review the literature on spirituality and hospice, my initial desire to conduct an ethnographic study found theoretical justification. In the next section, I describe the ethnographic approach and suggest the advantages of ethnography for the study of communication and spirituality.

Ethnographic approaches find their roots in anthropology and sociology, but have also gained prominence in the field of communication (Lindlof & Taylor, 2002). Ethnographic approaches allow a researcher to use the culture of a setting to make sense of observed patterns of behavior (Geertz, 1973; Van Maanen, 1979). This suggests two advantages for a communication researcher. First, through ethnography, I can observe

and record the actual communicative practices of organizational members. Second, by immersing myself in the life of an organization and conducting interviews with organizational members, I can begin to understand their motivations for action as well as the meaning and significance they attribute to organizational events. In this manner, I can begin to understand not only *how* employees communicate about spirituality at hospice, but also *why* they make the communicative choices that they do.

In addition to aligning well with my focus on communication, ethnographic methods also fit with my focus on spirituality. Any discussion of spirituality occurs within a particular organizational and societal culture. Geertz (1973) writes, "Culture is the creation of meaning through which human beings interpret their experiences and guide their actions" (p. 145). Examining an organization as a culture brings our attention to the manifestations of culture, such as stories, rituals, and artifacts, as well as to the important, underlying values and meaning systems that characterize the understandings of organizational members (Martin, 2002). Because spirituality is concerned with meaning making (James, 1902) and value structures, ethnographic methods have been suggested as an ideal approach for this topic area (Capper, 2003; Gonzalez 1994, 2003; McRoberts, 2004; Sass, 2000).

In order to even approach the achievement of such lofty goals as understanding the meaning structures of a culture, ethnographers spend significant time with cultural members, sharing in their experiences and listening to their stories. While some ethnographers choose to become full participants in a culture, in this study my role was that of a participant-as-observer (Lindlof and Taylor, 2002). As such, I was open about

my role as a researcher and observer, but I also joined in with the group and participated in group activities. The exact manner and procedures in which I interacted with the group are detailed in the next section; however, before we more on, a caveat must be offered.

In this section, I have described ethnography as if it were fully possible to understand and capture the experiences, sense-making processes, and meaning systems of staff members at CCH simply by "hanging out" with employees and listening to their stories. No amount of hanging out or listening will provide me complete access to the meaning system of another group. While the combination of ethnographic methods used in this study may illuminate more of the group's meaning system than interviewing or observation alone; it cannot illuminate the fully complex and constantly changing nature of any individual or group meaning system for the ethnographic encounter is always "diachronic, processual, and fragmented" (Crapanzano, 1986, p. 51). Thus, my report of events at CCH is but a partial report, guided as much by my own prejudices and biases as it is by the actual happenings and meaning structures at CCH. For as Geertz (1973) states, "What we call data are really our own constructions of other people's constructions of what they and their compatriots are up to…We are explicating explications. Winks upon winks upon winks" (p. 9). With this caveat in mind, we turn next to the research setting and procedures.

Organizational Context and Participants

Central County Hospice (CCH) is a mid-size hospice in the South with two offices serving seventeen counties. CCH was chosen for this study partly because of

their commitment to holistic health care, including spiritual care. In their mission, CCH promises to provide emotional and spiritual support to the patient and the entire family. This promise is upheld as CCH annually serves nearly 2,000 family and community members with bereavement and chaplain support.

Negotiating Access

The first step in any ethnographic work is negotiating access to the organization. In this case, my previous interviews with CCH staff helped pave the way for my entrance to the organization. I met initially with two of these interviewees who were intrigued by the project and they suggested that I prepare a short research proposal for the CCH CEO. This proposal was submitted to the CEO along with a copy of the research paper produced after the initial interviews with the CCH staff.

After reviewing both of these documents, I met with the CEO and director of mission support to discuss the project. This meeting served three purposes. First, I gained the approval of upper management and was allowed to conduct the project. Second, the CEO demonstrated an interest in research about spirituality and communication and had read my initial research paper. Finally, in this initial interview, the CEO suggested that the two CCH offices handle spiritual issues very differently; thus, job shadowing, interviews, and observations were conducted at each office. The focus on both offices allows for a comparative ethnography which serves to illuminate points of contrast and agreement that offer greater understanding of the role of spirituality in hospice. In the next section, I provide further information about the entire CCH organization, the culture of each office, and the community in which each is

located.

The Organizational Setting

CCH is a non-profit community owned agency that specializes in compassionate end-of-life care for patients living with a terminal illness. CCH's mission statement reads, "CCH is a non-profit, community-supported agency committed to caring for individuals touched by life-limiting illness, grief and loss. The goals of care are accomplished through a comprehensive, individualized plan including medical care of the patient and emotional and spiritual support for the patient and the entire family. Care is provided to all people in need without regard to race, age, faith, diagnosis, or ability to pay." Although this mission statement is quite comprehensive, when discussing the mission, most employees narrowed it down to one word--"comfort." In describing the mission, one nurse states, "It is to provide care and comfort for the patient and family, and making sure that patient is comfortable and their needs are met. Not just the physical needs, but to help them get their life in order…to make sure the patient dies in peace."

In describing the world of CCH, one must also directly address these issues of death and dying. I'll admit that when I first entered hospice, I was worried about such close contact with death. Everywhere I went, when I mentioned hospice, people would say things such as, "How does it feel to be around all of those dying people?" Certainly, hospice is largely misunderstood in America. During the process of data collection, hospice made national news, but seldom for anything positive. Rather, a hospice was the setting for the Terri Schiavo legal case in which a family was divided against itself over the removal of Schiavo's feeding tube. Schiavo, a 15-year hospice patient who was

living in a vegetative state, became the central focus for a national debate about the meaning of life and death (Eisenberg, 2005). Not surprisingly, this national attention only further reified the public's understanding of hospice as a place of death. For hospice workers, however, the notion that hospice is about death seems rather nonsensical. To hospice employees, the mission is not about death, it is about life, and not just any life, but a high quality life. Thus, the hospice offices are most often filled with staff sharing laughter, jokes, hugs, and funny stories that keep them focused on the joys of life rather than the realities of death.

These hospice staff members work as a team to create comprehensive, individualized plans for patient medical care and emotional and spiritual support for the patient and entire family. The physician-directed hospice care team includes: the patient's physician, hospice physician, skilled hospice nurse, medical social worker, certified hospice care aid, chaplain, volunteer coordinator, bereavement coordinator, and community volunteers. CCH has 65 full-time employees broken into two main care teams. The founding branch office, located in Oakville, employs 33 staff and the newer office, located in Mayburg, employs 27 staff. The remaining five employees work at satellite offices that are not involved in patient care, so they were not included in this study. In addition to paid staff, CCH is supported by strong volunteer support. Volunteer hours total approximately 24,000 hours of service annually.

Services offered by CCH include: individualized physical, emotional, and spiritual care plans for patients, support and guidance for families, in-home visits from the hospice care team, bereavement support for families, 24-hour on call nursing

assistance, and community education. The services offered by CCH are comprehensive and employees often go “above and beyond” exceptional patient care to meet the needs of patients and families. During the short five months I spent at Hospice, staff found an apartment for a patient’s family that had been evicted, donated their own clothing and furniture to needy hospice families, and collected food and purchased school supplies for other poor families. Employees and hospice volunteers donned hard hats and cleaning gloves and scrubbed patient’s homes, built wheelchair ramps, and repaired roofs and bathrooms. When a devastating hurricane hit a nearby area forcing thousands of evacuees into the community, hospice workers donated their time and medical expertise staffing shelters and providing grief counseling.

CCH provides care to all patients regardless of age, race, faith, diagnosis, or ability to pay for services. To be admitted, patients must have a confirmed diagnosis of a terminal illness with an estimated life expectancy of six months or less; understand that palliative treatment (rather than curative treatment) will be the focus of care; reside in a safe environment with available caregivers; and be within the CCH service area. All hospice care provided by CCH is provided in patient residences, usually a private home or a nursing home. CCH serves an average of 600 patients per year, with an average daily census of 77 patients. The average patient length of stay is 47.8 days. Although patient care is not provided within the CCH offices, patient family members, volunteers, and community members often visit the CCH offices for trainings, bereavement support groups, and meetings with social workers, chaplains, and bereavement staff.

Thus far, we have gained a picture of the entire CCH organization, an organization driven by a shared mission that includes a commitment to comfort care, a focus on life, a team based structure, and dedication to exceptional patient and family care. These four elements give us a significant glimpse into the underlying values of the entire CCH organization. We turn next to a description of each CCH office and its cultural context.

Including the cultural context is important for organizations never function in a vacuum, isolated from outside environmental pressures and resources. Martin (2002) argues that organizations are best conceptualized as a "nexus" in which a variety of internal and external influences come together. This study was conducted in the South, in what is often referred to as a "Bible Belt" community, during a time when the role of religion in public life was being hotly debated in newspapers, magazines, and television shows. During the time of my field work, the role of spirituality in public life gained national attention in special issues of *Newsweek* (August 29, 2005) and *U.S. News and World Report* (August 8, 2005). These magazines showed that 79% of Americans surveyed described themselves as "spiritual" and over 70% claimed to practice some kind of religion (Adler, 2005). This awareness of spirituality is particularly prominent locally in a state in which the governor makes a show of signing legislation at a church (Curry, 2005) and city council meetings often begin with prayer (Avison, 2005). Certainly, such an environment may influence the role of spirituality at hospice and the provision of spiritual care. Thus, we must also explore the social context in which

hospice functions in order to truly understand the role of spirituality and the enactment of spiritual care. We journey first to Mayburg, the smaller and newer of the CCH offices.

Welcome to Mayburg: Population 14,500. Mayburg is located about 35 miles from the university community in which I live. The drive to Mayburg takes me along small country roads, over rolling hills and past small farmhouses. During my early summer drives, I appreciate the lush green fields of flowers upon which cows graze. The same fields turn a golden brown in the early fall as days of 100 degree heat have sapped them of life. Forty minutes and a few country roads later, I pull into Mayburg. The fairgrounds on my right are always my reminder to look out for the turn into hospice coming up on the left.

As the fairgrounds and country roads suggest, Mayburg is a rather small town that retains much of its rural, largely German, heritage even as it is slowly invaded by retirees escaping from the busy city about an hour away. Newcomers remain suspect in Mayburg. In fact, my acceptance into the organization seemed to go much smoother when I dropped the name of my friend Lacey, a member of one of Mayburg's long-standing, respected families.

As it is in many small, rural Southern towns, religion is a driving force in Mayburg. Although a few Catholic churches can be found in town, most community members attend local Protestant Christian churches and church announcements are featured in the local paper almost daily. Although often unspoken, community members often operate from the presumption of a shared Christian heritage.

Along with farming and ranching, manufacturing and retail sales serve as Mayburg's economic base. It is largely a blue collar community with an average education level. Approximately 18% of the population holds a bachelor's degree and 6% holds a graduate/professional degree. Although the median household income is around $32,000, it is not unusual for hospice staff to provide care to families living below the poverty level in substandard housing. Of course, as in any town, there are wealthy families in Mayburg and CCH has served a fair number of them as well.

The staff here is a bit smaller than at Oakville and a larger percentage of staff is involved in direct patient care. Of the 27 staff, only three employees work solely in the office, two in medical records and one in reception. Because of the smaller number of employees, even these staff members may be called upon to drop off patient medications or visit with family members. For their workspace, the staff shares a two-story structure with a long warehouse that extends out behind it. CCH acquired this building just over a year ago and renovations were still in the final stages of completion as I began my field work. Early staff meetings were held amid the sounds of hammers and the scent of fresh paint. The building is actually an old beer storage facility and if you search hard enough you can find lingering signs of its former life.

The Mayburg staff members have conflicting feelings about this new office. On one hand, they enjoy the increased space and new surroundings that this new office gives them. On the other hand, since moving into the new offices about six months ago, the staff finds themselves much more spread out and they miss the family feeling of their older offices. Despite the fact that the new office makes communication a bit more

challenging, the Mayburg staff is committed to doing what they can to maintain their "family feeling." When I would job-shadow at Mayburg, it was obvious that all employees shared this commitment. During my first half-hour of job-shadowing with the chaplain, four employees stopped by the office. Two of them needed to share patient stories and two just wanted to check in and say hello.

The relaxed, family atmosphere permeated all events at the Mayburg offices. During the bi-weekly team meeting, there was always a bowl of candy or treats being passed around and shared by all. Joking and storytelling was common and laughter always close at hand. The Mayburg staff seemed particularly good at maintaining this team atmosphere and resisting the urge to fall back into the sub-groups of nurses, social workers and care aides. At Mayburg team meetings, nurses intermingled with chaplains, social workers with care aides. There were no assigned seats or subgroupings. In fact, sometimes we even met in different rooms or had the tables arranged in some strange haphazard fashion. As these observations indicate, the Mayburg staff maintained a flexible, casual, friendly, and family oriented work environment. We turn next to Oakville, where a diverse population and set of goals make things a bit more complicated.

Welcome to Oakville: Population 140,000. Oakville has nearly 10 times as many citizens as Mayburg making it in some ways a more diverse community. My office, at the university which is the economic and cultural center of Oakville, is located about ten minutes drive from CCH. I am always struck by the changing scenery as I drive up to hospice in Oakville. Upon leaving the university, I head across town on residential

streets that feature increasingly dilapidated homes and apartments which are the primary residences for the university's international students who need to be within walking distance of campus. Next, I cruise past the municipal golf course that has seen better days since the town's more affluent golfers have traded in the city's dry, brown fairways for the lush greens at the new country club across town. It seems many of the neighborhoods I drive through on my way up to hospice have seen better days as the city's more affluent folks have withdrawn to their country clubs and upscale housing developments.

The divide between rich and poor is rather prominent in this community. In fact, many divisions are evident here - among the most prominent, the division between Oakville and Pineland. Oakville and Pineland are the sister cities that form the main hub of CCH Oakville's 17 county service area. The physical distance between them is minimal, practically non-existent. The two cities are so close in proximity that they are often referred to as one, as I have chosen to do in most of this document, even collapsing together their two population totals to get 140,000. The daily paper serves the "Pineland Oakville" community and the local weather forecasts are always the same. The physical divide; however, may be one of the only *minimal* differences between the two communities.

Many of the divisions in this community are more prominent and these become evident as I drive past the sign demarcating the line between the two cities. My drive today began in Oakville, the location of the university, the local mall, and the movie theatre. The population in Oakville tends to be relatively affluent, highly educated, and

predominantly white. In fact, 58% of the Oakville population has a bachelor's degree and 30% has a graduate/professional degree. As I drive through Oakville, my windshield frames an image that would be perfectly appropriate for the next Gap catalog - well dressed students carry book filled backpacks as they lounge on the benches in front of the local pizza place. On the street behind them, top of the line SUV's vie with a Harley motorcycle, several very large pick-up trucks, and one convertible for the few available parking spots.

Within two miles, the image in front of me alters dramatically. The houses become smaller and the vehicles parked in front of them more often in need of repair. The children playing on the porches in front of their homes are more likely to be Black or Hispanic than White. Their clothes are more likely from Walmart than Baby Gap. The street I have to drive down to get to CCH must be navigated carefully in order to avoid the two teeth jarring potholes that seek to eat my car. There is no doubt that Pineville is the poorer of these two sister cities. The most recent census found that over sixty percent of the children attending school in Pineville were poor enough to be classified "economically disadvantaged." Only 11% of Pineville residents hold an advanced degree. Still, all is not in decline here in Pineville. After decades of decay, the city planners are trying to revive the community and the constant construction downtown is evidence of forward progress. The downtown area is slowly being re-invigorated by an infusion of antique shops, coffee houses, the occasional boutique, and an art gallery. Yet the renaissance is far from complete. Abandoned buildings, dilapidated store fronts, a free health clinic and several resale shops sharing the downtown streets of Pineville give

testament to the difficulties of reviving the forgotten glory of this community.

Despite all of these differences, some commonalities unite the two communities. Both tend to be rather conservative; few Democrats find their way into public office around here. Prayer begins all school board meetings and most of the community supports this practice. A recent newspaper survey showed that 63% of community members surveyed believed that school board meetings and city council meetings should begin with prayer. Of course, when the city council decided to follow along with the school board and begin all meetings with prayer, a barrage of editorials were printed in the newspaper from angry folks opposing the practice suggesting a community much more divided over issues of religion than we might find in Mayburg.

The prominence of religion in the community is evidenced in the high number of faith groups here. Even in my short four mile drive from the university to CCH, I pass five churches, two Christian schools, three buildings which serve as meeting space for Christian student groups, and the offices of two Christian faith based charities. Despite this strong Christian presence, other religious groups do operate in Oakville. Places of worship can be found for those of Unitarian, Hindu, Buddhist, Muslim, Jewish, and Bahai traditions, to name just a few. Certainly, Christian organizations are the most prominent in this community--a source of frustration to some hospice workers and celebration to others.

Perhaps, the clearest indication of the role of religion in Oakville is evidenced in the greeting that newcomers receive when they move to town. Several hospice staff members had moved to Oakville from other places around the country and they all

shared a similar story when I asked about the role of spirituality in Oakville. Tape 22[2] states, "When I came here, the first thing I heard when I was introduced to people was, 'Hi, nice to meet you, what church do you go to?' Coming from a place out of state where anything goes, it was total shock and I didn't know how to respond." Although Oakville welcomes many more newcomers than Mayburg, in many ways Oakville is just as traditional.

The interior of the Oakville offices is a bit more polished and professional than the interior at Mayburg. This could be a sign of the more finished state of the Oakville building, but I think it is more likely an indication of a difference in culture and priorities. Oakville is the "big office," the founding office where most administrative and management personnel work. The Oakville offices are large with management and financial staff on the second floor, social service staff and receptionists on the first floor along with two large conference rooms, and the nurses and medical records staff have offices in the lower level. These physical separations are a good representation of the divided culture that is sometimes apparent in Oakville as the team breaks up into subgroups of nurses, care aides, and social workers.

In sum, the staff in the Oakville and Mayburg offices share a commitment to providing excellent palliative care; however, there are significant differences within the

[2] In this dissertation, research participants' comments are identified by audio tape number rather than by pseudonyms. I recognize that this depersonalizes the comments; however, there are two pragmatic advantages to such an approach. First, it is difficult to keep all comments confidential when members of this small organization read this dissertation and my hope is that the use of numbers as identifiers will cover up the gender of participants and provide for one more level of distance between the participant and the comment. Second, I used numbers as opposed to names in an attempt to separate my scholarly analysis from my relationships with research participants. In the data analysis phase, I learned that it was emotionally more comfortable to analyze comments offered by "Tape 2" than to analyze comments offered by "Michael."

offices and their surrounding communities. In Mayburg, unity is often presumed both in the office and in the community. Within the office, the staff members are protective of their relaxed family atmosphere. In like manner, the community members are protective of their traditional shared religious and community heritage and remain suspicious of newcomers. Whereas unity is the prevailing presumption in Mayburg, diversity is the prevailing presumption in Oakville. The growing cultural and religious diversity in the Oakville office and community have resulted in a reexamination of traditional religious values and an increased openness to individual difference and diversity. As is often the case, the increased diversity in Oakville is also occasionally a cause of confusion and conflict. In the forthcoming results chapters, I will explore further the manner in which these different assumptions about unity and diversity influence the role and management of spirituality in the organization. Before turning to these results, I must describe more fully the data sources and data collection procedures utilized in this study.

Data Collection

Once access to the CCH offices had been granted, I began to detail more fully my data collection procedures. When conducting ethnographic work, a researcher can assume multiple roles ranging from complete participant to complete observer (Lindlof & Taylor, 2002). For this study, I assumed the role of a participant as observer (Lindlof & Taylor, 2002). I entered the organization explicitly to collect data for this project, but also with a desire and a willingness to participate in organizational activities and help out in any way that I could. This role choice had several advantages. First, it seemed only fair that all organizational members were aware of my ultimate goal of researching

and writing, a reality that isn't always made clear in the complete participant approach. Second, I did not have the organizational familiarity to be a complete participant and entering as an observer allowed me to act out my very real naiveté by asking questions and probing for additional information. In addition, functioning as a participant-as-observer allowed me to assume multiple vantage points and see the organization from several different perspectives. Because CCH depends so fully on volunteers, I was able to be more of a participant in some volunteer capacities helping out with bereavement activities and outreach. Once this role choice was made and all research procedures were approved by the university's review board for the protection of human subjects, I was prepared for organizational entry.

To introduce the project to all organizational staff, I attended a team meeting at each office during which I introduced myself and provided an overview of the project. At the Oakville meeting, following my presentation, the CEO informed the staff that participation in interviews was optional, but encouraged. The chaplain, who had participated in my previous study, also vouched for me, mentioning my good listening skills and the healing potential that interviewees might experience as they tell their stories. At the Mayburg meeting, no management staff was present to introduce me or my project, so establishing rapport was initially more difficult, but through continued visits, the Mayburg staff became more comfortable with my presence. Next, I detail more fully the participant observation experiences, formal interviews and organizational documents which serve as the basis for analysis.

Data Sources and Procedures

Participant Observation. Over the course of five months, I spent 230 hours at CCH attending various functions. At the Oakville office, I attended six bi-weekly interdisciplinary team meetings. All patient care staff and some of the administrative staff attended these meetings, which lasted about three hours each. During the meetings, the organization managers made announcements, the bereavement staff led a brief memorial for all patients who had died in the two weeks, the lead nurse and social workers introduced new patients, and the staff was updated on the condition and any pressing needs or concerns of existing patients. I also attended a six-week volunteer training class and a six-week bereavement group. I spent several days job-shadowing in different areas of the office including: nursing, social work, bereavement, reception and medical records.

Although most of my observations were conducted in the office, I did one "ride-along" with the marketing liaisons and one ride-along with a nurse. During my visit with the nurse, I visited several patients in private homes and nursing homes. Patient and family approval of my visit was secured prior to the ride-along. Due to the ethical dilemmas posed by the intrusion of a researcher into the homes of hospice care patients, I rarely interacted directly with patients. Certainly, this restricts access to certain types of data; however my ethical choice was to refrain from interviews with patients. Instead, I relied primarily on care provider narratives as a window into the interactions between patients and providers. At the end of data collection at the Oakville offices, I attended the semi-annual community memorial service in which family members of patients who

have died within the last six months come together with hospice staff members to celebrate their loved ones.

At the Mayburg office, I attended nine bi-weekly interdisciplinary meetings which followed a similar format to those in the Oakville office. However, in the Mayburg office, all staff except for one receptionist attended the meetings. In addition to these meetings, I attended a community memorial service, an open house at which approximately 200 community members visited the new Mayburg offices, and bereavement luncheons. I job-shadowed in several areas of the hospice including social work, medical records, bereavement, and reception and served as a counselor at a day-long camp for bereaved children. I also conducted ride-alongs with a social worker and a chaplain. Finally, I attended a day long retreat in which staff from all offices came together for a day of community building, goal setting, and reflection upon the hospice mission.

These observations generated 239 single spaced pages of field notes. When appropriate, I took "scratch notes," handwritten notes detailing my observations of the office environment, reflecting upon the impact of my presence upon the environment, and recording verbatim quotations from hospice staff (Lindlof & Taylor, 2002). These handwritten notes were fleshed out and transformed into typed notes within 24 hours. At bereavement events attended by families and during visits to patients' homes, I did not take scratch notes in order not to make the patients and family members feel uncomfortable. Instead, I took "headnotes," memorizing images, conversations, and reflections as fully as possible (Lindlof & Taylor, 2002, p. 159). Immediately upon

departing these events, I typed observations, conversations, and reflections into my field notes. Intermittently during data collection, I also kept a journal recording my own personal observations and emotional reactions to my experiences at hospice in order to help track and articulate the impact of my subjectivity on the final results.

The hospice staff seemed to become quite comfortable with me over time and about two months into my field work, one of the staff members told me that I needed to get a job at hospice. She informed me that they're "getting so used to seeing my smiling face around here that I just need to be here permanently." Certainly, this blending in demonstrated that I was becoming more of an insider which gave me privileged access to organizational data and members' stories. At the same time; however, I was reminded that the more I blended in as a participant in the organization, the more likely the staff members were to forget that I was an observer which required me to be careful to gain informed consent to share participants' stories and reassure participants that their responses were confidential (Capper, 2003). From time to time, staff members themselves would remind me that my presence was not invisible as they would turn to me and say, "Is that going in your book?" There are certain stories which are not included in this final document because they were shared in moments where I believe the confidant forgot about my research role and was talking to me as a friend. In other cases, participants explicitly asked me not to share or record certain things and in this final document. I have taken care to balance academic honesty and rigor with the wishes and needs of study participants.

Interviews. The second major source of data is 42 semi-structured in-depth

interviews. The majority of interviews were conducted during the first six weeks of this study. About a week after my initial introduction at the team meetings, signup sheets for hour long interviews were circulated in both offices. The Oakville staff, who had been encouraged by management more directly to participate, signed up quickly. The Mayburg staff were slower to sign up for interviews as they did not know me, nor did they have management or co-workers encouraging them to sign up. Thus, the first week of conducting interviews at Oakville, I interviewed 15 people and in the first week of interviewing at Mayburg, only five. However, after interviewing with me, several Mayburg staff went out to "recruit" other employees to participate and I soon had many more people signing up.

Twenty-three interviews were conducted at the Oakville offices. Participants included: social workers, nurses, a volunteer, a care aide, bereavement staff, the organization president, the volunteer coordinator, medical records staff, receptionists, marketing staff, and the chaplain. Nineteen interviews were conducted at the Mayburg offices. Participants included: bereavement staff, the volunteer coordinator, nurses, social workers, care aides, volunteers, medical records staff and receptionists. In total, 40 of the organization's 65 employees participated in formal interviews. Several other employees participated in informal interviews during my observations. All members of the management staff were interviewed and at least one representative of each organizational division was interviewed. All notes and interview audio recordings were transcribed yielding 419 single spaced pages.

Interviews were conducted in order to understand the participant's experiences

and perspectives regarding the role of spirituality at CCH (Lindlof & Taylor, 2002). Once participants had signed up for an interview, a location for the interview was determined. When staff members had their own offices, they generally invited me to conduct the interview there. Other staff members had a cubicle or shared office space with several other employees, so we sought a more private environment. At Oakville, this was found in the "replenishing room," a small room approximately 8 feet square painted in a soft green with a couch and upholstered wing chair. This room was designed for employees to use as an escape or after a particularly difficult patient encounter. The purpose and décor of the room created a calming effect and the interviewee and I would generally collapse into the comfortable couch with the tape recorder between us to conduct the interview. In Mayburg, their "replenishing room" has only a bed as it is used more for on call nurses who need to catch up on sleep or employee's sick children who are brought along to work when they can't go to school. Obviously, it wasn't a good choice for interviews, so Mayburg interviews were conducted in a small conference room or vacant office.

The process of interviewing followed the three step format for ethnographic interviews suggested by Spradley (1979) and elaborated by Stage and Mattson (2003): establishing the explicit purpose, engaging in ethnographic explanations, and employing ethnographic questions. I began the interviews by establishing the *explicit purpose*. I stressed that the project was being conducted in part to fulfill the dissertation requirements of my PhD program. I further explained that the goal of the project was to explore spirituality at hospice and the goal of the interview was to understand how each

participant understands spirituality and its role at hospice. After this explanation, I paused and asked participants if they had any questions about me, my project or their role. Most didn't ask any questions, but a few asked about my background. At this point in the interview, interviewee questions were mostly related to my explicit purpose and included inquiries about the time frame of the project or the experience of graduate school.

Second, through *ethnographic explanations,* I suggested how these interview goals might be achieved. I began by explaining that participation in the interview was optional and would require them to sign an informed consent form. I presented the form and explained that all responses to interview questions would be kept confidential and names and identifying information would be removed in the final project. I informed participants that the interview would probably last about an hour and made sure that they didn't have any time constraints. Second, I inquired as to the interviewee's willingness to be recorded on audio tapes that only myself and my transcriptionist would be able to access. 37 participants agreed to the audio recording. Five participants requested not to be taped, so handwritten notes were taken during these interviews. Participants who agreed to be audio-recorded were informed that they could ask me to stop the tape at any point in the interview.

Next, I briefly outlined the five major topics we would be discussing in the interview. First, I would ask participants to tell me the story of their career and their journey to hospice work. Second, I would ask about the role of spirituality at hospice. Third, I would ask participants to share stories about interactions with patients, co-

workers, and managers where spiritual issues were involved. I explained that because interactions with patients would not be observed for ethical reasons, I would appreciate any detailed stories about patient and care provider interactions that participants were willing to share. Fourth, I would ask about the best and worst parts of the job and how they coped with stressful situations. Fifth, I informed participants that I would save time at the end for any follow-up questions that they or I might have about the interview. Once this outline had been provided, I told participants that I knew I was asking some sensitive questions and reassured them that it was fine to say, “I don’t know” or “I don’t want to talk about that.” Further, I told them that I wanted this interview to be as much like a normal conversation as possible and that they could feel free to ask me any questions they wanted throughout the interview. Finally, I set the tape recorder and (after learning from the first interview) a box of Kleenex between us and we began.

In the third step of the interview, I asked a variety of *ethnographic questions* to guide the interview. I wanted to guide rather than direct the interviews, so I chose a semi-structured approach that allowed me to adapt to new situations and different interviewee needs (Kvale, 1996). To prepare for the interviews, I created an interview guide which consisted of four major topic areas and a variety of suggested questions. These topic areas were described above and a full interview guide is attached Appendix A. Typically, the interview began with a grand tour question about the interviewee’s career path and journey to hospice (Lindlof & Taylor, 2002). In some cases, particularly in early interviews, this guide was closely followed as I was less comfortable with the interview procedure and had little familiarity with the organization and participants. As

my familiarity grew, I added new questions suggested by my observations. For example, in the original interview guide, I did not include a question about the Hospice Workers Prayer. In observations, I noted that the recitation of this prayer was a regular ritual so a question about the prayer was added. I also adapted questions based upon the interviewees' job experiences. For example, employees who worked solely in the office were asked more about inner office discussions of spirituality and less for patient related stories.

The interviewees' comfort level also required some adaptation of the interview guide. Some interviewees were less comfortable with the topic of spirituality, so we began by talking about their job tasks and the hospice philosophy and worked our way into the spirituality topic as interviewees became more comfortable. Other interviewees wanted to tell me about their spiritual perspectives and ideas immediately, so we began with them and worked our way out to the more general hospice related questions. In concluding the interview, I used a clearing house question (Is there anything else you think I should know about you, hospice, or the role of spirituality in hospice as I move forward with this study?) to give interviewees an opportunity to share information that my previous questions had not elicited.

Finally, I asked participants if they had any questions for me. Approximately half of the interviewees had questions for me and they tended to be much more personal in nature than their questions at the beginning of the interview. Participants inquired about my own spiritual beliefs, my motivations for undertaking the study, my family and marital status and the timeline for graduation. Certainly, these questions seemed fair

after the amount of self-disclosure of interview participants. Often my answers would elicit further conversations and stories on their part and some of the richest interview data was gathered as the interviews came to a close. These reciprocal questions were helpful in three ways. First, in sharing more about myself with participants, I established a sense of goodwill, trust, and reciprocity that proved helpful in building relationships as I continued with participant observations. Second, it was a useful reminder of how it feels to be asked personal questions by a relative stranger and it kept me aware of the risk participants undertake when they agree to these interviews and reminded me to respect and honor the research process. Finally, in attempting to answer participants' questions about my own spiritual beliefs, I realized the extent to which my beliefs influence my worldview, and as I tried to articulate my beliefs, I realized that it is both difficult and frightening to talk about spirituality at the beginning of a new relationship because one does not want to offend the other party. This difficulty proved to be shared by many participants and is discussed more extensively in the next chapter. We turn now to the final data source.

Organizational and Community Documents. Prior to and during the course of my observations, I collected a variety of organizational documents including: website posting, annual reports, newsletters, brochures, and articles about CCH in the local newspaper. In addition, I received approximately 200 pages of documents during my participation in volunteer training and approximately 150 pages of documents in preparation for the six week bereavement group.

Data Analysis and Interpretation

Data Management

In order to manage such a large data set, all data sources were transcribed and sorted into computer files. I transcribed my own handwritten field notes, notes about organizational documents, and 11 interviews. In order to speed along the process of data management, I hired a professional medical transcriptionist to transcribe the remaining 31 interviews. In transcribing interviews, care was taken to maintain the messiness of speech for broken sentences, laughter, and unusual word choices can reveal a lot about the speaker, the topic, and the situation (Mishler, 1986). Although the participants' words and obvious instance of laughter or tears were recorded verbatim in the transcripts, the transcripts did not record pause length between sentences or any nonverbal changes in tone or emphasis of the speaker. Transcripts were prepared in this manner for two reasons. The first is purely utilitarian, preparing transcripts according to the exact notation strategies used by conversational analysis is both expensive and time consuming (Lindlof & Taylor, 2002). Second, this type of transcript was deemed suitable for the chosen method of grounded theory and narrative analysis. To check the work of my transcriptionist, I listened to two audiotaped interviews and compared them to the written transcript and found that the written and audio taped files were a perfect match.

While the transcripts were being prepared, I reviewed my field notes and organizational documents and found that a portion of them had little to do with the management of spirituality at hospice. Thus, I attempted to reduce these data sets to a

more manageable level by selecting only those portions that dealt with spirituality. For the organizational documents, this included two booklets on handling grief, two newsletter articles, one summary of a bulletin board, and the general hospice brochure. In reviewing my field notes, I selected only stories and observations which dealt with some aspect of spirituality and meaning making reducing my field notes from 239 single-spaced pages to 57 single-spaced pages. Obviously, determining what data gets included and excluded at this stage was a difficult process. As Lincoln and Guba (1985) argue, this is more a process of data induction than data reduction. I began by considering my initial broad definition of spirituality as "a sense of meaning and connection." I combined this with my knowledge of hospice culture and experiences as I looked for instances of spirituality. Some of these were quite clear and included obviously spiritual rituals such as prayer or a discussion of a patient or family members' spiritual perspective. Others were less clear, but seemed to suggest something about the underlying spiritual culture and sense making at hospice. In deciding what gets included, I erred on the side of inclusion. As Lincoln and Guba (1985) argue, "It is easier to reject what later appears to be irrelevant material than to recapture information suddenly realized to be relevant but discarded earlier" (p. 346).

Preparing these reduced field notes also helped me to begin initial theorizing about the issues and tensions related to spirituality at hospice. By the time all transcripts were prepared, I was intimately familiar with a large portion of the data – both the field notes and the 11 interviews that I had transcribed. This familiarity helped me to begin theorizing about initial themes and categories. Based upon my field notes and these 11

interviews, I outlined five major categories of data: manifestations of spirituality, hospice mission discussions, spirituality stories, Oakville/Mayburg office comparisons, and explanations of the purpose of spirituality in the organization. This tentative coding scheme was used in the data analysis process that is described next.

Data Analysis

In the first stage of data analysis, all transcripts, notes from organizational documents, and the reduced field notes, were uploaded into Atlas.ti, a qualitative software analysis program. This program was used to sort, separate, and categorize the various data sources. The first step in this process was selecting quotations for categorization, a process often referred to as "unitizing" the data (Lincoln & Guba, 1985). This initial unitizing process is often both inductive and intuitive as one looks for "chunks of meaning" in the data (Marshall, 1981). Following Lincoln and Guba (1985), selected units had two characteristics. First, they were heuristic, that is, I perceived that the quotation offered a piece of the answers to the questions of this study. Second, the quotation selected was the smallest piece of information that could stand by itself. In some cases, units consisted of a single sentence. In other cases, units included entire paragraphs of talk because the interviewee's narrative could not be broken up without losing the context and thus, the underlying meaning of the story for the interviewee.

As quotations were selected, the initial coding scheme was refined. Codes, generally single words or short phrases that captured the meaning of the quotation, were assigned to each unit of data (Strauss & Corbin, 1990). I began assigning codes from the tentative coding scheme described above. In the initial coding process, I selected a

quotation and compared it to previous incidents and the 23 codes in the initial coding scheme. This reflects the constant comparative method of data analysis suggested by Glaser and Strauss (1967) and expounded by others including Strauss and Corbin (1990) and Lincoln and Guba (1985). In some cases, the data did not fit into any of the pre-existing schemes and new codes were created. This initial sorting generated 53 different codes which were collapsed into eight categories: role of spirituality in the organization, role of spirituality in individual jobs, manifestations of spirituality, spirituality and patient care, coworkers and spirituality, personal spirituality, community and spirituality, and stress (a copy of this coding scheme is attached Appendix B).

Once the data were analyzed and sorted, I began the process of interpretation. I began with axial coding in which codes and categories are compared as a researcher looks for connections between categories in order to generate themes (Strauss & Corbin, 1990). I began this process by returning to my original research questions and comparing them with the data collected. My original research questions fell into three categories. The first three questions asked about organizational level discourses and organizational member behavior, particularly in terms of spiritual discourse. The second set of questions (questions five and six) inquired into interpersonal communication about spirituality between hospice workers and patients or family members. The final research question asked about the impact of spiritual discourse upon individual employees. While these three categories – organizational, interpersonal, and personal issues related to spirituality – remain intact, the exact questions that are answered have been altered as new and more interesting themes emerged from the data. As is often the case in

interpretive ethnography, the things a researcher sets out to find and the questions the researcher sets out to answer do not always prove to be the most fruitful or interesting findings of the ethnographic endeavor (Markham, 1996). Certainly, this was true in this case and in the next section, I outline the transition from the original research questions to the results that follow. These descriptions are separated into three categories and they offer a brief preview of the three chapters of results that follow.

Chapter III: Organizational Discourse. In following with my original research questions, to flesh out the primary organizational discourse and the tensions and conflicts it created and reacted to, I began by examining the quotations regarding spirituality at the organizational level, beginning with quotations in the category "role of spirituality in the organization." Because several of these quotations revealed a connection between the role of spirituality in the organization and the role of spirituality in the community, I followed the steps of axial coding and read and re-read these two categories of data together comparing one to the other. This process revealed that the organizational perception of community spirituality affected the manner in which spirituality was managed at the organizational level. Because of this observation, I decided to conduct a more critical interpretation to explore the variety of goals that determine how spiritual discourse is produced at the organizational level and how organizational members respond to these goals. Using Eisenberg's (1984) concept of strategic ambiguity as a guiding framework, I returned again to the interviews, field notes, and organizational documents to search for and examine moments of ambiguity and inconsistency. This analysis suggested a multiplicity of organizational goals that

were largely managed through ambiguous communication. Further this analysis suggested that ambiguous communication came with related costs and benefits for both the organization and organizational employees. These results are described more fully in Chapter III.

Chapter IV: Spirituality and Patient Care. In order to explore the manner in which hospice workers communicate about spirituality with their patients and with patients' family members, I began by looking at the quotations in the category of "spirituality and patient care." The analysis of field notes and interview transcripts yielded 110 different stories of patient care-provider interactions. Subsequent analysis of these stories suggested that care providers face a uniquely communicative dialectic as they seek to provide exceptional spiritual care. I articulate this leading-following dialectic and explore the strategies that care providers use to cope with this dialectical tension. In order to explicate these management strategies, I reviewed literature on organizational tension and interpersonal dialectics and created a list of possible management strategies. I then used this list as an initial coding scheme to analyze care providers' communication strategies. Through the constant comparative method, I was able to revise and refine this list in order to capture the variety of care provider management strategies. These are discussed more fully in Chapter IV.

Chapter V: Spiritual Care and the Care Provider. To explore the influence of spirituality on the personal identity and outcomes of hospice workers, I began by examining the quotations in the categories "role of spirituality in the job" and "personal spirituality." Because the first two results chapters clearly indicated that the managerial

discourse at hospice established a preferred organizational identity (Tracy & Tretheway, 2005), I looked for moments in which organizational members discussed, invoked, and challenged this preferred identity in their narratives. This analysis revealed two categories of prevailing assumptions about spirituality, spirituality as mystery and spirituality as certainty, which influenced care providers' performance of the preferred identity. These spiritual understandings, and the impact they had upon care providers' experiences of stress and burnout, are considered more completely in Chapter V.

Evaluating Interpretations

Lincoln and Guba (1985) suggest several strategies that can be used to ensure the trustworthiness of qualitative data: prolonged engagement, triangulation, and member checks. All three are evident in this study. First, I spent considerable time in the organization, 230 hours over a span of five months. This time in the organization was preceded by extensive reading about hospice in general as well as a review of information specific to CCH including: newsletters, annual reports, and local newspaper articles. My departure from the organization came only after reaching a point of saturation, the point at which new themes and ideas were no longer emerging from my observations.

Second, I used multiple methods in order to look for converging and diverging interpretations. Two methods of triangulation were utilized. First, multiple sources at hospice were consulted in order to view the management of spirituality from multiple perspectives. These perspectives were differentiated by both job task and community. Second, multiple methods were used to collect data. Interviews, organizational

documents, and observation notes were compared with one another in the verification of final themes.

Third, member checks were conducted with organizational members throughout the project and are currently ongoing in with regard to the final results. During the process of data collection, I regularly discussed my thoughts and theories with two key organizational members who listened to my ideas, often confirming them, but occasionally questioning and challenging my conclusions which led to a refinement of this theorizing. Further, this entire document will ultimately be provided back to organizational members and their comments elicited before final publication. Fourth, I participated in peer debriefing sessions with several members of my graduate advisory committee which helped me to process both my emotions and my theoretical ideas.

Finally, because this entire project is shaped by my own private interpretations and meanings, I have attempted to clarify moments in which I felt my presence clearly shaped the data. I often speak in first person voice to articulate the impact of my own subjectivity upon the findings as I did in the description of negotiating access to the organization. In line with this attempt at reflexivity, in closing this chapter, I articulate how my own positioning might affect the results.

Two aspects of my story seem most central to this project. First are my experiences with spirituality and second, my lack of experiences with death. In terms of spirituality, I consider myself a spiritual woman, but my understanding of the spiritual continues to evolve. In my youth, I attended a fundamentalist Christian church and followed a legalistic, often restrictive and judgmental spiritual path. Finding that this

didn't work for me, I began exploring other spiritual paths. After several years of searching and questioning, I find that I still believe in a higher power. For my part, I experience and encounter that higher power largely in and through the teachings of Christianity although I also encounter the sense of a benevolent higher power through other spiritual teachings and a connection with nature. Because of my spiritual background, I am much more sensitive to the issues surrounding the integration of Christian spirituality in the workplace. As this study was conducted in two primarily Christian communities, my experiences with both fundamentalist and progressive Christianity help me to understand more fully the influence of Christian spiritualities in this context. At the same time; however, this sensitivity to Christianity creates less sensitivity to other spiritualities. One manner in which this is managed in this study is through peer debriefing with colleagues from other spiritual backgrounds.

Finally, I believe that my lack of personal experience with death was both a help and a hindrance in this project. I have been to two funerals in my life, both for distant acquaintances. I have not personally experienced the death of a close friend or family member nor have I stood at the hospice bedside of a loved one. On one hand, this lack of personal experience served as emotional protection during this study as I didn't have to mentally relive the death or funerals of loved ones as I heard others' stories about death and dying. On the other hand, without this experience, my ability to empathize with patients and family members was somewhat limited. I tell my story so that you will understand where my starting point for analysis is as you challenge my insights with your own. As Gonzalez (2003) states, we must report our results with "tentative

certainty” so that “our experience of sharing our knowledge can become transformed from one of masterful authority to one of spiritual engagement with the universal wholeness of what it is to be a human, social being” (p. 503).

CHAPTER III

THE ORGANIZATIONAL DISCOURSE

"*It's kind of powerful, isn't it? I mean it's obvious it's there. It's there every day. It's very much a group effort. It really does work and it's just wonderful to be a part of. It's kind of alive like. It has a heartbeat almost. It's there."*

CCH employee describing the role of spirituality at CCH

As demonstrated by the above quotation, spirituality is so central to CCH organizational life that for this employee and many others, it seems to be the heartbeat that drives the organization. In this chapter, I answer the first three research questions by examining this powerful discourse about spirituality. In particular, I consider the internal and external demands that influence the spiritual discourse at hospice and the manner in which this discourse creates its own set of tensions for organizational members. Finally, I discuss the manner in which organizational members experience and respond to these tensions. I begin by articulating the prominent themes of the spiritual discourse at CCH.

When employees talk about spirituality at hospice, it is obvious that meeting patients' needs is the driving force for the inclusion of spirituality in the CCH mission. As we discussed in Chapter I, spirituality is often most important in times of uncertainty as it provides a way to make meaning of meaningless events (McGuire, 2002). The uncertainty of death has been provoking spiritual thought and questioning for all of human history and spirituality can become particularly important as many patients go through an end-of-life faith review process (Kubler-Ross, 1969). Tape 1 sees hospices'

spiritual care as fundamentally important in helping patients through this process. She states, “The mission of hospice is to comfort those at the end of their life’s journey, to help make that transition to the next life peaceful and as pain-free as possible. Actually helping them spiritually too because we have a lot of families that have never gone to church, don’t believe in God, and don’t want to hear about it. Those people at the end want to see the chaplain. And those are just the ones that really touch your heart. You feel like you make a difference.”

The provision of “spiritual support” is written into the CCH mission statement and a commitment to such care is evident in both offices. Each office employs a part-time (approximately 30 hours per week) ecumenical chaplain. These chaplains visit any patients or family members that request to see them. Upon intake, patients are asked if they are receiving spiritual support, and if they wish to receive more spiritual support, the chaplains will be notified and visit. Even when the chaplains don’t visit patients, patients and families report receiving exceptional spiritual care. Tape 4 states, “In the family satisfaction survey that is sent to the caregiver about six weeks after the death of a client…very often people will say that the spiritual care was good when they never saw the chaplain.” At hospice, any employee might provide spiritual care. Nurses, care aides, and even receptionists have been known to listen to the spiritual concerns of patients and family members and even offer a prayer.

In comparison to other hospices, CCH pays special attention to spirituality. Most for-profit hospices have a service ratio of one chaplain per 300 patients. At CCH, the ratio is one chaplain per 40 patients. This aspect of the CCH mission is often celebrated

by employees, particularly in terms of the inclusive nature of CCH spiritual care. Tape 36 states, “In our work and support groups, we treat everybody regardless of whether they have a Christian faith or whether they are Muslims or whether they are Atheists. We meet them where they are and try to help them work their way through whatever problems they have.” In fact, the commitment to spiritual care and the organizational openness to spirituality are so strong that some view hospice as a spiritual organization. Tape 18 states, “You know it’s the spirituality that runs it. You don’t have to put a cross on the wall, and you don’t have to put the Torah anywhere in the building to show off religious affiliation because the people that work here are that spiritual power. They got it in ‘em. And everybody knows it when they walk in the door.”

Obviously, spirituality forms a large part of CCH’s organizational mission. But what, exactly, does spirituality and spiritual care mean at CCH? In many ways, this is a difficult question to answer because CCH takes a deliberately ambiguous stance when it comes to questions of spirituality. In this chapter, I explore the justification for this ambiguity, the manner in which spirituality is manifested at each of the CCH offices and the outcomes of this approach to spirituality. I set up this discussion by briefly examining the literature on the strategic use of ambiguity in organizations.

Strategic Ambiguity

In 1984, Eric Eisenberg challenged the prevailing assumption that openness and clarity should always be the overarching goals of organizational communication. In this article, Eisenberg rejects the notion that communication is about discovering and transmitting some pre-existing objective reality; rather, he suggests, communication is

an interactional process of meaning construction (Watzlawick & Weakland, 1977). In some situations, particularly those in which organizations are trying to achieve multiple, possibly conflicting goals, and appeal to multiple audiences, the strategic use of ambiguity might be advantageous.

Eisenberg suggests three potential benefits of strategic ambiguity. First, strategic ambiguity may promote unified diversity within organizations. Organizations must find a way to balance cohesion and coordination with individual freedom for flexibility, creativity, and adaptability and an ambiguous statement of core values allows for a variety of individual interpretations while maintaining the appearance of agreement (Contractor & Ehrlich, 1993; Leitch & Davenport, 2002; Markham, 1996). For example, Contractor and Ehrlich's (1993) study of a loosely coupled research foundation found that four different stakeholders groups each interpreted the foundation's ambiguous mission statement as a reflection of their own interests. Thus, each stakeholder group supported the new foundation and all stakeholders were able to coordinate effectively around this ambiguous goal.

Strategic ambiguity can also facilitate change. Miller, Joseph, and Apker (2000) found that strategic ambiguity was used by a health care organization in facilitating the change to a care coordinator directed system. In this study, nurses were given strategically ambiguous role assignments that allowed them to adapt their job tasks and job design to respond to different situations. Strategic ambiguity may also be used during a period of change to buy an organization time and space to determine internal change mechanisms while keeping external publics happy (Davenport & Leitch, 2005).

Third, strategic ambiguity can amplify existing source attributions and preserve privileged positions. While this can benefit individuals with power, it can cause problems for subordinates. In an ethnographic study of an architectural design firm, Markham (1996) found that management used strategic ambiguity to preserve the existing power structures of the organization. Employees were given strategically ambiguous directions in order to encourage their "creative potential" but were often subject to explosive, critical outbursts following the exercise of this creativity. In this manner, ambiguity became a means of control and caused stress for employees because they couldn't resolve the contradictions between what they thought freedom meant and what their boss apparently thought it meant.

As Markham's study suggests, the use of strategic ambiguity is not necessarily unproblematic and previous research suggests three additional potential pitfalls. First, ambiguity may border on the edge of lying and deception and unsavory organizational members may use ambiguity to increase the deniability of their actions and avoid legal prosecution (Tyler, 1997). Second, while some enjoy the freedom suggested by ambiguous job roles and organizational mission statements, others find this ambiguity stressful and desired more direction from management (Markham, 1996; Miller et al., 2000). Third, organizations cannot control the manner in which stakeholders interpret their ambiguous statements and stakeholders may reach an interpretation that mobilizes dissent and resistance rather than fostering unified diversity (Davenport & Leitch, 2005).

While these studies have examined the use of strategic ambiguity in several different settings, none of them has examined the use of strategic ambiguity as a method

for creating unity when the source of diversity is different spiritual perspectives. Thus, this chapter begins by examining hospices' strategically ambiguous position regarding spiritual care. I begin by exploring the enabling and constraining forces that affect CCH's handling of spirituality and lead hospice employees to use an ambiguous style of communication. In this section, I focus on ambiguity that is part of the more formal, organizational communication strategy aimed particularly at external audiences. I also explore how this strategic use of ambiguity is interpreted by individuals both inside and outside of the organization. Next, we move away from the use of ambiguity at this macro organizational level and bring our attention to the use of ambiguity within the hospice team. In each of the cases, I discover that ambiguity can be as beneficial as Eisenberg promised. However, these results also suggest that the use of ambiguity, particularly in spiritual matters, can be highly problematic for it may serve as a point of contrast around which resistance may be organized.

Hospice: A Spiritual Organization

We have already established that CCH, as an organization and a group of team members, values spirituality. In this section, we explore CCH's communication choices regarding spirituality. This analysis suggests that CCH's handling of spirituality is influenced by a desire to appeal to multiple audiences including patients, family members, government funding agencies, private donors, and other community organizations. As an organization, hospice deliberately uses the ambiguous term "spirituality" as an umbrella term that can be interpreted in multiple fashions according

to the needs of audience members. CCH management hopes that this strategic choice will allow CCH to be open to all spiritualities, but to privilege none.

Official hospice brochures include “spiritual care” as a component of hospice services and the “ecumenical chaplain” is listed as a part of the care team. Other than this mention, spiritual care is never defined in official, public documents. If you ask staff members to define “spiritual care” at Oakville, the immediate response is a celebration of the diverse nature of the community and the inclusive manner in which CCH provides spiritual care. In fact, the ambiguity of spiritual care is so protected in Oakville that when the chaplain was hired, she was discouraged from putting the title “Reverend” on her business cards because it suggested a Christian spirituality.

No one at hospice will tell you exactly what spiritual care means. Instead, they will list a multitude of definitions and tell stories about providing spiritual care to individuals from a wide range of faith traditions. Tape 44 states, “We try to keep reminding ourselves that spirituality can manifest in several ways and it may contain deity figures, it may have a real nice package religious sect name to it. It could be meditation, music, nature, and another one with all the normal ones, there is one that I’ve added, I think there are people who derive tremendous spiritual strength out of a sense of family. There are some families that have spiritual characteristics that give them strength.” Other employees don’t even attempt to put any sort of definition upon “spiritual care,” but instead rely on story after story to illustrate the concept. These stories suggest that “spiritual care” can include a wide variety of actions including: singing, painting, drawing, praying, Bible reading, listening, hugging, and telling stories.

As these comments demonstrate, CCH management refuses to endorse an official CCH spiritual perspective in formal communication. They will agree that hospice is "spiritual" but only when spirituality is defined in a broad and inclusive manner. The hope is that this ambiguity will promote unified diversity and allow patients, family members, and others in the community to read the spirituality they desire in hospice. Tape 44 states, "I think that people bestow spirituality and different forms of religion on us because they need us to have it so we can help them through things that their spirit needs done. That's the circle. We serve. They want us to serve, they empower us to serve, they lay down the stepping stones and they bestow characteristics upon us, which may or may not be true, because that's what they need us to be in order to help them. I think that's the way it works." Thus, hospice management hopes that by leaving hospice spirituality open to interpretation, they will be empowered to serve all patients.

The second factor influencing CCH's official communication about spirituality is pressure from public and private funding sources. Medicare and Medicaid requirements dictate that hospices provide some type of spiritual support in order to receive funding. As CCH receives 69% of their funding from these agencies, the pressure to comply with these requirements is strong (CCH Annual Report, 2004). In addition, CCH receives 25% of their funding from private memorials, donation and fundraising and Tape 44 reports that perceptions of hospice's spirituality can affect donor behavior. Tape 44 states, "For sure, I think that one of our greatest, one of our continual sources, of probably $4-5000 per month is from adult Sunday school classes…because they believe, they interpret that because we respond to people that are dying, we are doing religious,

Christian and spiritual interventions and therefore they support us." Hospice management recognizes that exhibiting an ambiguous spirituality that can easily be read as a Christian spirituality can help in securing these donations.

Third, hospice employees themselves influence communication about spirituality. Many hospice employees believe that CCH staff members' appreciation for the spiritual realm is essential to mission accomplishment. Tape 6 states, "Spirituality is very important. It helps to get a lot of these employees through the day." Tape 11 details why spirituality is so important: "I do not think you can come into a mission like this and not go a little deeper. At some point, it is going to affect you and cause you to have questions. It is gonna make you say, why? I don't think you could solve that riddle being an atheist. I do not think you could handle working in this type of environment doing that. To me there just has to be a higher power there that can bring some help." The turnover in hospice organizations is generally quite high and CCH is no different; hence, any factor that keeps employees motivated and energized is appreciated. At the same time, hospice staff members may come from a variety of spiritual traditions, so the organization must find a style of communication that encourages and allows spiritual sense making and coping, but does not privilege one spiritual system over another. As we shall see, this is much easier in the Mayburg community where none of the employees openly practices any religious tradition other than some form of Christianity. In Oakville, one of the employees is openly Jewish, so questions of spiritual diversity are more present. Thus, the third reason for promoting an ambiguous spirituality is to meet the needs of diverse employees.

In sum, CCH prioritizes spirituality in patient care, but projects and protects a broad, ambiguous definition of spirituality in order to appeal to a diverse audience and meet a variety of organizational goals. This broad mission also allows for each CCH office to determine exactly how to facilitate the spiritual mission as needed in order to meet the needs of their surrounding community. Because the Oakville and Mayburg communities are so different, the manner in which this spirituality is manifested is different in Oakville and Mayburg. To demonstrate these differences, I examine the manner in which each office handles the public presentation of prayer, prayer which occurs at hospice events that are open to staff, community members, patients, and families. This analysis demonstrates that the first two goals, patient care and community reputation, drive the public presentation of CCH's spirituality as the staff in each office adapts their speech patterns according to the perceived spirituality of the community.

Public Prayer at CCH

During my five months of field work, I witnessed seven occurrences of public prayer at hospice. In all of these situations, prayers were part of larger ceremonies in which prayer is a common ritual. Prayers were offered at both the Mayburg and Oakville community memorial services. Prayers were also offered at Mayburg bereavement luncheons and the children's bereavement camp. We begin by examining public prayer in Mayburg.

Public Prayer in Mayburg. All of the public prayers offered in Mayburg were explicitly Christian. At the community memorial service, a biannual gathering at which hospice workers, family members, and friends gather for an informal ceremony to honor

all hospice patients who have died in the past six months, we prayed together twice. The first prayer, offered to bless the meal before we ate was clearly Christian in nature as it began with “Dear Heavenly Father.” At both the Mayburg and Oakville memorial services, lunch was followed by a ceremony in which all attendees get together to plant a tree in memory of their loved ones. The tree was placed in a previously dug hole and each family was given a small clay pot containing soil. The pots were wrapped in colorful cellophane tied with a brightly colored pipe cleaner. As the name of each patient was read, family members come forward to add their pot of soil to the dirt around the tree. Then the ceremony was closed with another clearly Christian prayer mentioning that all those who were gone were now being watched over by God.

During the children’s bereavement camp, we also had prayer twice. One of the volunteers led us in prayer before lunch and again during a final balloon ceremony in which the children released balloons to which they had tied messages for their deceased parent or loved one. The prayer at lunch was again obviously Christian beginning with “Dear Heavenly Father” and ending “In Jesus’ name, Amen” and during the balloon ceremony, we were invited to join together in the *Lord’s Prayer*. Most of the staff and volunteers joined in, and a few of the children knew the words and joined in as well.

At the Mayburg bereavement luncheon, one of the bereavement staff prayed for our meal. She began her prayer “dear heavenly Father” and went on to thank God for grace and help in all the hard times. Her prayer concluded, “In Christ’s name, amen.” As I stood in the kitchen reflecting on the juxtaposition of the supposedly secular spiritual commitment of hospice with the clearly Christian language in this prayer, one of the

luncheon attendees remarked to me, “Gosh, I hope everybody is a Christian.” This attendee was not upset by the Christian prayer, but her comment suggests that it was not just my research focus that made me so aware of the Christian language present in this ritual.

Later on that day, I asked the prayer leader about her decision to have a prayer and her language choice within that prayer. She told me that she hoped the prayer was “meaningful” for luncheon attendees. But she also said that you have to know the group and be aware of any “atheists.” She said she might have to use God’s name in a different way if there were atheists present; however, since she knew exactly who would be attending the luncheon and knew their spiritual traditions from the intake forms, she knew there were not any non-Christians present. This was also the case at the children’s camp. She went on to say, “In Mayburg, we don’t have to be as careful here, in the rural area. However, in Oakville, they need to be more mindful of the different faiths.” Interestingly, at this point, she gets up from her desk and goes to the framed CCH mission statement on her bookshelf and reads me the commitment to “care for all people in need without regard to race, age, faith, diagnosis or ability to pay for services.”

This suggests that the purpose of the Christian prayer language in Mayburg is to serve the Christian population seeking services, yet the staff remains aware of the need to possibly alter their language should “atheists” begin coming to bereavement events. However, the exact manner in which this might be done, at least in terms of public prayer, remains a dilemma for this particular staff member. When I asked how the prayer might change if people of other faiths were present, it was obvious that she had no ready

answer and she stopped to think for several moments before concluding, “I would have to use God’s name differently in that case. I’ll have to think more about that.”

While this comment suggests some willingness to adapt spiritual communication practices to meet patients’ needs, it also demonstrates a prejudice toward deity centered spiritualities. This care provider’s solution to the presence of atheists is not to eliminate the prayer, but to alter the manner in which God is referred to in the prayer. For the true atheist who doesn’t believe in the existence of any God, this solution may not be satisfactory as any prayer, even one to an ambiguous God, may be upsetting.

These public prayer performances suggest that in Mayburg, the clear exigence is to meet the current needs of the Christian community, especially the needs of current Christian patients and families, in order to be accepted and provide the best patient care. The Mayburg staff and the CCH administration at large recognize that they are still relatively new in a community that doesn’t take quickly to newcomers and they are committed to fitting in and establishing a good reputation. CCH’s CEO is particularly aware of this fact and states, “There is much more religion in Mayburg and less spirituality with the German, Czech Lutheran stuff and it is very religious…Very different set of values. You look at Oakville, there are two Jewish organizations here, two Morman organizations here. You aren’t going to find a Unitarian church in Mayburg, you aren’t going to find female pastors. So certainly again, the community has less cultural diversity…I think that all calls for us to be aware, to be different. But you know, if you are going to serve, you do what you need to do to serve. You have to figure

it out…You can't alienate people in Mayburg because then you won't be doing hospice. I think we have won over the citizens in Mayburg, finally."

The use of Christian language in the public presentation of spirituality at Mayburg seems to serve its intended purpose. During my time at CCH Mayburg, it became obvious that many community members viewed hospice as a Christian spiritual organization, the members of which were doing God's work. During the Mayburg office Open House, I helped park cars and escort community members to and from the office. During these walks, CCH workers were often referred to as "angels" and the organization as a "blessing from God." In sum, the use of Christian language is the preferred solution to reach the goals of providing exceptional patient care and establishing a positive community reputation. The ambiguity of CCH's spiritual mission allows for this interpretation of spirituality in Mayburg.

Public Prayer in Oakville. When it comes to spirituality, Oakville is a unique place. Christianity is a strong force in this conservative, Southern, Bible Belt community, and a large majority of CCH's donors and patients find their Christian faith to be a great source of comfort and inspiration. At the same time, there is a vocal, non-Christian minority in Oakville that CCH is committed to serving. This pluralism presents a clear dilemma for hospice staff. How do they communicate their organization's spiritual identity in order to establish a reputation that makes patients and families of all spiritual tradition (and those that have none) feel comfortable supporting CCH and coming to them for end-of-life care? To respond to this dilemma, CCH Oakville follows the strategically ambiguous official position even in their public prayers.

Public prayer was much less common in Oakville and the community memorial service was the only time during my fieldwork that I observed any public performance of prayer. The language of the prayer was deliberately ambiguous and open to a variety of interpretations. The fact that a prayer was offered before lunch suggests an appreciation of the spiritual while the language of the prayer, begun with "Dear God" and ending with "Amen," deliberately avoided an exclusively Christian tone. This language is intentional and the hope of the prayer leader is that those who are Christian will find comfort in the moment of prayer and those who are not will appreciate the ecumenical, inclusive language. Certainly, this prayer language reflects the use of strategic ambiguity in an attempt to bring unified diversity.

This more ambiguous prayer language was also present in the prayer at the closing of the memorial service. As we gathered for the tree planting ritual, the staff member leading the memorial began by talking about the tree's journey from a forest, to a nursery, to the store, to this spot in front of hospice and used the analogy that all of us have journeys in life and death is just another stop on our journey. She then read the name of each family and they came forward to add their pot of dirt. Once all had added their memorials, the leader said a prayer for all of the families. Like the lunchtime prayer, this prayer was openly ecumenical and had no explicit mention of Jesus or heaven.

Clearly, strategic ambiguity is the option chosen in Oakville, but is it effective? Several Oakville employees reported that individuals within the community had made comments to them about what a "Good, Christian Organization" CCH is. Tape 15

reported that a community friend recently commented, “Hospice has just been wonderful. You do such great things and you are a Christian organization!” At the same time, the staff in Oakville seems to successfully reach out to non-Christians as well. At Oakville, staff members have served patients from Hindu, Muslim, Bahai, Jewish, and Unitarian backgrounds. They care for Atheists and Agnostics. This seems to support Eisenberg’s (1984) notion that individuals will “project” into messages a meaning that is consistent with their own beliefs. By refusing to clearly define their spiritual perspective, hospice allows for a greater latitude of interpretation and thus can more easily serve a variety of patients.

This ambiguity can also provide an umbrella under which both CCH offices can operate. While both offices define themselves as spiritual organizations, the manner in which spirituality is manifested in each is different and these differences are not accidental. In fact, hospice management is open about these strategic choices. Tape 44 states, “To be very candid, one must market and package oneself a certain way. One must market and package yourself a certain way, regardless of what you know you are…because the social and business configurations that you travel in have certain requirements.” Adopting an ambiguous mission of “spiritual care” allows for hospice to adapt to different communities and patient care situations.

Of course, the use of ambiguity at Oakville has not been entirely unproblematic. Recall that one of the advantages CCH Oakville claims for their use of ambiguity is that it allows stakeholders to interpret CCH actions in the manner that is closest to their own belief system. One potential pitfall of allowing stakeholders to determine your belief

system based upon your actions is that they may not always interpret your actions in the manner you meant them to be interpreted. The management staff is particularly aware of this as they experienced a violent drop in donations and support in 1994 when their actions were interpreted in a manner counter to some people understanding of appropriate "spiritual" behavior. Tape 44 explains, "The other side that was true was in 1994 - 95 when we were taking care of so many AIDS patients was how much hate mail we got and how many hate phone calls we got saying things like, 'I'll never give you another dime.' And 'Don't you know the Bible says, you can't do this and you can't do that.' So people were judging our spirituality because we were serving people they think we shouldn't serve."

As this comment suggests, some people may interpret CCH's openness, their commitment to inclusive spiritual care that meets people where they are, as a sign of a closed rather than an open spiritual perspective. This suggests that there may be limits upon the use of strategic ambiguity when it comes to questions of spirituality. For some people, the very use of ambiguity is counter to their spiritual and theological belief systems. Underlying the theory of strategic ambiguity is the expectation of a relative world with a multitude of meanings, in which truth is found through communication (Eisenberg, 1984). This very assumption is problematic for those from spiritual perspectives in which the very notion of relativism is sinful and the world should run according to one notion of Truth. Hospice then faces a paradoxical situation. They use strategic ambiguity as an attempt to transcend religious divides and offer comfort to as many people as possible. Unfortunately, it is just this move that is discomforting for

certain people. This paradox becomes increasingly obvious when we examine internal communication about spirituality in the form of the Hospice Workers' Prayer.

Staff Prayer at CCH: The Hospice Workers' Prayer

At both CCH offices, the staff members share a "prayer" at each team meeting. In line with the official hospice spiritual position, this "prayer" is deliberately ambiguous and the inclusion of this prayer is driven by the belief that spirituality may bring comfort and connection. The "Hospice Workers' Prayer" was written at a staff retreat approximately ten years ago as a mechanism to band staff together and renew their commitment to the hospice mission. The prayer reads, "Spirit of hospice, shine in our hearts. Spirit of hospice, deliver us from despair. Spirit of hospice, be our support, as we care for the precious lives entrusted to us. That we may be confident that we are instruments of infinite mercy, hope, peace, and love. Amen." In both offices, the prayer is part of the memorial moment for those patients that have died within the past two weeks.

According to hospice management, the primary purpose of the Hospice Workers' Prayer is replenishment and team building. Tape 44 states, "The hospice prayer…is supposed to be a way for people to say things that are replenishing to them and it is kind of a verbal proxemics to bring them together. The other thing is they need that. One of the things that is interesting about hospice is…you find that people who come to hospice have tremendous capacity to care, but they are almost impaired in their capacity to receive care…so you somehow want to make sure that there are mechanisms and opportunities for staff to care for each other." The hope of Tape 44 is that by sharing in

this memorial moment, staff will be drawn together once again around the mission of hospice.

The language of the prayer is deliberately ambiguous so that it can serve as a point of connection for all staff, whatever their religious or spiritual background. Another member of the management team suggests, “It is a response to what we do. A comfort measure. So that’s how I take it and I think it is designed well enough that you can take it whichever way you need to take it for your spiritual belief system.” This seemed to be a common feeling among the employees. Tape 35 says, “It’s pretty, it’s not specific and I think that’s why they use it because it doesn’t have any specific religion or tone to it.” Clearly, this is an example of strategic ambiguity intended to promote unified diversity, but does it work?

Most of the staff enjoys this ritual and their comments suggest that the ritual performance of the prayer can truly be a moment of connection with one another. Tape 18 states, “We have the Hospice generic prayer at the meetings. That struck me when I first came here as something very powerful. When you’re in the Scouts, which I never was, you have certain things you say. Clubs you have certain things you say; businesses you have certain things you say. High School you have a school song, you have a fight song. I don’t think this is any different. It’s a movement, like a rally, to bring unity. So it’s not offensive in any way. I think anyone who works here, as I’ve said before, has the feeling that they are on a particular mission and are a group of people who are spiritually connected.” Tape 28 also uses an analogy with other community rituals and states, “I have no problems with that. I’m 43 so especially if you say the old school, I remember

saying prayer in school. I remember saying the Pledge of Allegiance. I remember prayer at football games. I have no problems with that." However, Tape 28 goes on to add, "Where people say it offends them, what's the difference in offending me by not doing it? You should tolerate each other."

Those who work more directly in patient care also found the prayer comforting for it served as an ideal moment for reflection upon and release of their deceased patients. Tape 34 states, "You have time to look back on all the families that you've helped. You have time to just really think about what that prayer really means. In that prayer it describes what our mission is. You just have time to reflect back on a lot of moments that you've helped. That's what it means to me." Tape 23 adds, "It's a positive experience for me. Especially when I know some of the people [who died]. It's a good thing because we never put them to bed without a prayer." Tape 43 adds, "That is the closure. That is the closure of grieving. I know every word. And pretty much we all have it memorized, because we all say it. So that's my closure." For these employees, the recitation of the prayer is an ideal end to the memorial moment of remembrance for all patients.

A final benefit of the Hospice Workers' Prayer" is that it may serve to appeal to the more traditional, religious community members in both Mayburg and Oakville. When asked why the Hospice Workers Prayer is labeled "prayer" even though it is really more of a team building statement, Tape 44 responded, "It is marketing (laughter). What would you call it? You could call it an oath, you could call it a pledge, you could call it a mantra. You throw it out in the marketplace and prayer is the best label, so you throw it

out in the marketplace and people say, ‘Oh, we have our own hospice prayer.’ It is not, it is not a prayer. When you look at it, read it, it is exactly what it is. It is seeking togetherness and wisdom and affirmation of what we do. I don’t know what else you would call it.” Again, we see that hospice is making language choices that are clearly strategic and designed to appeal to as wide an audience as possible.

Unfortunately, the prayer at hospice doesn’t always serve its intended purpose as a point of connection and a moment for renewal. The failure of the prayer to fulfill its intended purpose suggests two possible failures of strategic ambiguity. First, the ambiguity can allow for interpretations that are contrary to those desired by management. Second, the ambiguity can serve as a point of contrast rather than as a point of connection. I turn next to a closer examination of these problems.

One problem with the use of a strategically ambiguous prayer is that team members may not interpret the prayer in the comforting manner that it was intended. For some the moments of reflection during the prayer bring less release and more reliving of the deaths that they have witnessed. Tape 32 states, “I guess there are times when it hits me kind of hard. Especially when somebody is gone that I really cared about. Prayer does that to me. You can ask my pastor. There’s not too many Sundays that go by that I don’t have tears in my eyes. To be perfectly honest with you there are probably days where I try not to think about it too much, what we are saying. I guess that sounds really ugly but you know I cry so easily that if I really think about what we are saying and start putting it with my patients I start crying and I don’t like to cry all the time. I know crying is a good thing but my eyes get swollen and then I look like heck the rest of the

day." Tape 37 adds, "It's like you never forget them. It's like since I started here I still think about the patients I did see. You know we never forget them."

Even though these staff members sometimes experienced the prayer as somewhat painful, they believed it was a positive ritual for the staff and had learned to manage their discomfort individually by emotionally and cognitively disengaging from the moment. Tape 35 describes this process of detachment. She states, "I think there's a point where you have to kind of close it off for a little bit because I think if you allow that much to be there it would be overwhelming. When we read down those names we go, 'I'll miss seeing them' or 'I hope they're doing ok.' Generally when they go down that list when we have that moment of silence I'll think to myself, 'God bring some comfort to these families.' Just to put a thought out there." By deliberately disconnecting emotionally and focusing more on the release of patients, Tape 35 was able to reclaim the positive aspects of the prayer.

Some employees also found the prayer problematic because the ambiguous language of the prayer served as a point of contrast with their private expectations for prayer and made them feel separated from others at hospice. The CEO notes that one new employee was incredibly frustrated by the ambiguity of the prayer. He states, "When she first came, it drove her nuts. She couldn't stand it. She said, 'This isn't a prayer.'" She is not alone in these feelings. Another employee told me, "You might not want to hear my answer to this. I don't know who started the prayer or whatever. I have a problem with it because you don't pray in the name of Jesus. They're praying in the spirit of Hospice, well who are you praying to? The spirit of Hospice? So I have a little

bit of a problem with that prayer. That might seem silly to most…I think that sounds like you're praying to the spirit of Hospice. Well that is not appropriate to me. So I've never said it." A third employee noted that the prayer was too "New Age" and also refused to say it.

When employees encounter ambiguous or contradictory communication, they try to make sense of it and to do so they draw upon their pre-existing rules and resources for sense making (Miller, et al., 2000). To make sense of the hospice workers prayer, these care providers drew upon their own more traditional belief systems which suggest that prayer should be directed to Jesus. Thus, they were uncomfortable with this prayer and refused to join in saying it. This illustrates a significant dilemma for organizations trying to incorporate the spiritual side of life. When they borrow traditional religious rituals and terms such as prayer, they are at risk of also bearing all of the expectations that accompany these rituals and terms (Giddens, 1984). Even though hospice has deliberately written a very ambiguous, spiritual "prayer," their choice of the "prayer" label has religious connotations for many and when these religious expectations are not met, they are uncomfortable.

Like the performance of prayer at the Oakville memorial service, the title and language of this prayer are differentiated in an attempt to achieve potentially conflicting goals. The title "prayer" may appeal to the religious folks at hospice and in the community that are comforted by the fact that hospice has a prayer while those who are not religious can read the language of the prayer and dismiss it as more of a "mantra" or "oath." Of course, the comments of the staff reveal that meeting both of these goals

simultaneously may be impossible for the dramatic inclusiveness of the language may exclude those who prefer more traditional prayer and the very existence of a "prayer" may exclude those who don't believe in God and find offense in religious ritual.

No hospice staff members reported that the prayer was "offensive" because it was too religious. Those that were less religious simply interpreted the prayer as a team building exercise and reported no dissonance. However, there were several employees that privately reported problems with the prayer because it wasn't religious enough. In the final section of this chapter, we examine how the more religious employees at hospice resisted this organizationally sanctioned ambiguous spirituality and attempted to reclaim the comfort of their own Christian beliefs. The differences in the office environments at Oakville and Mayburg led to differences in the manner in which this resistance was manifested; thus, I once again turn to each office individually.

Resistance in Mayburg. In Mayburg, just two individuals criticized the Hospice Workers' Prayer and both did so only after ensuring that we were behind closed doors. The target of their criticism was the "New Age" language of the prayer and the fact that everyone seems to be expected to join in the performance of the prayer. These workers, both committed Christians, reported being very uncomfortable with the prayer. They managed their discomfort by simply being present for the prayer, but refusing to join in reciting the prayer. While this may seem like a minor act of resistance, the manner in which the Mayburg staff conducts the prayer ritual makes this resistance quite obvious.

In Mayburg, the Hospice Workers' Prayer is part of a memorial ritual at every team meeting. The Mayburg bereavement staff members light a candle to signal the

opening of a moment of silence and then the name of each patient that has died in the past two weeks is read. Many of the staff rest in traditional prayer position during this ritual and often you can hear staff members crying as they remember the patients for whom they have provided care. In concluding the memorial, all staff read the hospice workers prayer. To ensure that all staff can participate, copies of the hospice workers prayer are distributed along with the patient list at the beginning of every Mayburg team meeting.

Because all members of the Mayburg hospice staff receive a copy of the prayer and share in the recitation, refusal to say the prayer must be more of a deliberate act of resistance. In Oakville, only one staff member says the prayer and it used to be that way at Mayburg as well, but shortly before this study the practice changed. The initiator of this change states, “I find it very helpful to me to say it verbally. Any type of talking helps me get through things. If I don't say something, or I can't talk, I feel like it's still closed in. It helps, just like you're going to church in shedding a prayer. It's just like saying the Lord's Prayer to me. The hospice prayer is for the hospice patient. The Lord's Prayer at church is for the community and my family. That's how I relate the two.”

Like the initial creation of the prayer, the decision to share in the recitation was motivated by a desire to help the staff process their emotions and feel replenished. When asked about the staff reaction to the change, the initiator stated, “They loved it. I did not have anyone that didn't, that didn't want to say it. It is certainly by choice. I don't look around to see if everyone is saying it because I'm so involved with it. So I don't know if

everybody does, but I know there's a lot of voices I think, if it is too upsetting, then probably they wouldn't say it. You know, they would have tears during that time." Certainly, there are those in Mayburg who do get teary during the prayer time and choose not to say it. There are others, however, whose desire not to say the prayer comes not from feeling emotionally overwhelmed, but rather from discomfort with the "new age" language of the prayer.

Although there were only two employees in Mayburg who mentioned such discomfort to me, they did not mention their discomfort to the management. It is likely that the team oriented culture in Mayburg discourages this kind of resistance to a long standing ritual. Obviously, the fact that so many voices participate in the performance of the prayer suggests a widespread appreciation for it. Further, the common theme in Mayburg is a sense of unity. When asked about conflicts over spiritual issues, the oft repeated answer in Mayburg is, "We don't have those. We're all on the same page around here." During my field work, in most things, the Mayburg staff did appear to be more "on the same page" than the staff in Oakville.

The silent conflict over the hospice workers prayer may also suggest that it isn't always the case that everyone is in agreement, but rather, the staff in Mayburg may be more willing to subjugate their individual needs to the will of a cohesive group. In their interviews, these staff members framed their criticisms of the prayer within a larger context. Even those staff members that were less comfortable with the language of the prayer concluded their comments by reflecting upon the positive nature of the entire memorial ritual.

Finally, staff members at Mayburg may not have felt a strong need to publicly voice their concerns about the New Age nature of the prayer because they were able to find other outlets for more Christian expressions of spirituality. In Mayburg, staff members were allowed to conduct more Christian prayers in public and discuss their own Christian faith in the conduct of their hospice role. Hence, even though some Christian staff members felt uncomfortable with the Hospice Workers' Prayer, they were able to find enough moments of Christian connection in their other hospice experiences to keep them satisfied. We turn next to examining resistance in Oakville, where the projection and protection of ambiguous spirituality can become a point of resistance for some staff members.

Resistance in Oakville. Within the Oakville office, there is a group of staff who would like to see CCH operate as more of a Christian organization. One member of this group of staff did take concerns about the "New Age" nature of the Hospice Workers' Prayer to management. In Oakville, the management solution to this problem was for the employee not to join in the prayer, a feat easily accomplished in Oakville because only one person, usually the bereavement coordinator, says the Hospice Workers' Prayer out loud. This allows those who want to join in the prayer to pray silently and others to participate only minimally. As with the public performance of prayer, this procedure allows for a wider range of beliefs and comfort levels with the prayer. While this solution seemed effective to management, it once again signaled a key problem for some of the Oakville staff – the manner in which the need to project an ambiguous spirituality silenced their own spiritual beliefs and limited the possibility that they would find

spiritual strength and support at CCH.

This group supports the CCH commitment to care for all and would not change the CCH mission of inclusive care; however, they would like to have more of an opportunity to talk about Christian spirituality and share prayer with patients and coworkers. Tape 5 states, “I really wish to be freer to be able to express [my Christianity], but of course you deal with so many different faiths and religions and places that they are coming from, you know. I understand that you can’t just be a Christian for the patient, which you know I would wish for it to be, but I do understand. I wish we could offer, and we do we have a chaplain, but the thing that bothers me is all the people worrying about stepping on their toes and boundaries or something. You know that whole thing I wish could be a little freer to the people.”

Tape 14 adds, “Spirituality here is not what it used to be… There were times that we would sit down and we would talk, you know. You know about, did you go to church, what did you learn? When I first started working here, we would sit down and talk about OK, what happened Sunday, what’d you do Sunday? Did you go to prayer meeting?...Then the nurses, there was a big change in nurses, and they weren’t there. Just a few of us still working and we tried to keep it going on, but with the new people coming in, you don’t want to offend anybody.”

The staff members who want to have more of a Christian organization find great strength in their faith and they believe the strength offered by a greater prominence of faith would be good for the organization. Tape 5 states, “Well, you know, if everybody could acknowledge and let God be inside, and acknowledge that, and let it be His

organization, it could really change a lot of things. I also think there would not be some of the problems that there is today. But of course that is everyday life with God in your life or not. I think it could make a change as there are definitely some things that could be better if people could let that be more of a part of their lives…That is what we want for the world. I have it and I want everybody to have the same."

During my field work, there was no overt discussion of this conflict within the organization, but during interviews it was quite evident that several staff members wanted more openness to spiritual talk among co-workers at CCH. However, these employees were uncertain how to bring up these desires without offending anyone in what one employee called the "Uber-ecumenical" culture of CCH. Tape 14 states,

> It concerns me, it really does concern me. I don't know and there are times when I want to get into it and want to ask and want to know. But not being directly involved with them [staff in other departments], I don't want to just walk up and ask those types of questions, "Are you religious?" You know in normal conversation, you don't…I can say I know most everybody goes to church but going to church and being Christian and really truly being there are two different things. You can go to church forever but that doesn't mean you're a Christian or that you truly believe. I tell my kids, "Are you religious, are you going just because I said you go, because I asked you to go or are you participating, do you feel it in your heart? Are you there?" That's one of those things I would like to know but I'm kind of afraid to ask co-workers, "Do you go to church, how do you feel about religion?" I can't do that because there are some people who strike

> out and say, “Why do you need to know that? Back off.” I’m not directly involved with them so I don’t feel I can go out and do these things, say these things anymore. But I’ve read that there’s a barrier, I really did.

The cultural presumption of diversity at the Oakville office breeds an increased awareness of the potentially offensive nature of spiritual talk. Yet, from these employees’ personal experience, spiritual talk can also be a very powerful source of strength and stress reduction. Thus, these employees are faced with a dilemma, how can they create opportunities to receive spiritual support themselves and offer it to other co-workers? Clearly, hospice management suggests that people should come together around an ambiguous spirituality and leave the discussion of specific religious beliefs behind. However, for these employees this cannot be the answer because ambiguous, vague discussions of spirituality cannot provide the same support as a deep connection with a fellow believer.

Currently, to meet their own spiritual support needs, these staff members have sought out the other like-minded Christians within the organization and have formed a network of support. They meet for prayer on an ad-hoc basis to pray for the organization, patients and staff. Tape 1 states, “We’ve had times, tough times, when we will all get together and have a little group prayer in an office and that really does; it does help your day. Because there are times when just going in there and praying and just hearing other people pray is just soothing. So, then I can go back and just do what I was doing. It changes your whole mood.” Tape 5 adds, “We will find out things that are real important to people and we will address this, maybe it is the medical staff, and pray a lot.

Sometimes a lot of stress from the people around you, you know…maybe a personal problem from home and things like that, and we just try to find out as may things as we can and pray fro this group, individuals, in knowing that God will really work through it for them. Reaching people and touching people, so that is what we do."

Of course, the reality is that some hospice staff members may be as uncomfortable with these Christian prayer meetings as these staff members are with the Hospice Workers' Prayer. However, the grace of hospice workers is evident in the fact that staff members who didn't desire these Christian prayer meetings still tended to view the desire for prayer as a well-intentioned act. Tape 26 states, "It doesn't feel like I have to, I don't think like everybody else does and those that choose sometimes they'll have a little prayer meeting or something when there's something rough going one, but they never, it's never like you feel like you have to participate." Tape 12 adds, "Some of them talk about it all the time, religion. It is beautiful…It does not bother me because I know the way that they are. That is not how I am personally, I would not do that, but it does not bother me."

One employee did mention that she sometimes felt uncomfortable with these prayer meetings, but even she approaches them with grace. Tape 25 stated:

> Sometimes it's awkward. Sometimes it's like I'm trapped into it. Like I said I am spiritual, but I don't like, I mean that was one of the taboo subjects. You don't talk about money; you don't talk about politics, religion or sex. That's just the way I was brought up. I don't mind having discussions about spirituality but, sounds terrible and I'm sure a lot of people here are different, but that's not

> usually the first place I go. I do make an offer if that's something that particular person, if they sound like they are going toward the religious side. I do, I will get into it then, but to me that's very awkward. I think I've had religion as a younger kid shoved down my throat by certain, what do you want to call them, sectors. Like the Baptists, I shouldn't even say that because there are a lot of Baptists downstairs. You know back home, the Baptists and the Jehovah's Witnesses were a thorn in my side so like I said, I don't like it shoved at me. I do feel that a lot of times you get trapped into that kind of stuff. We do say a prayer of a type after every, they go through the list of everybody who has passed away. That doesn't bother me at all. I actually rather enjoy that because meets my needs because I can meet and think of particular people that I want the families to have extra care and things like that.

Again, this comment reflects a desire to allow others to express their spirituality as they like, even when it is difficult. Note how she attempts to differentiate the bad "Baptists"—those back home who try to shove religion down one's throat and the good "Baptists"—those who work downstairs who are granted more leniency and given the benefit of the doubt because they are fellow members of the hospice team.

Although this narrative begins expressing frustration with prayer, the narrative ends with an affirmation of the more ambiguous, Hospice Workers' Prayer and an appreciation of the spiritually replenishing role that this serves. Thus, the narrative illustrates the tensions that spirituality in the organization evokes for many. On one hand, are employees like Tape 25, who view spirituality as largely a private experience –

one, that like political views and sex, should not be talked about in polite company. Yet, these employees also express an appreciation for the potential benefits of spiritual experiences, such as the ambiguous hospice workers prayer which allows them to reflect on their service to patients. For these employees, Oakville's strategy of ambiguity as a response to diversity is a powerful solution. Because CCH accepts the spiritual as a fundamental part of human experience and encourages employees to respect diverse patient spiritual perspectives, employees from this perspective are able to practice these principles with coworkers as well as patients.

On the other hand are employees, like Tape 14 and Tape 5, who express a strong desire to have more spiritual conversations. They believe in a powerful God through whom great things can be done at hospice. Their spirituality imbues every aspect of their lives and as Tape 5 says, they would like everyone to be able to share in this spirituality. Thus, they want to talk about spiritual issues. In fact, because their spirituality imbues everything they do, to not be able to pray or talk about lessons learned at their churches feels like having to remain silent about a large portion of their lives, their very selves. Yet, these employees also appreciate the fact that the CCH mission does appreciate spirituality and they don't want others to be offended by communication about religious or spiritual issues. These employees know that they work in a diverse environment, and they need to respect the hospice dictum of accepting patients and coworkers where they are and not proselytize to them or offer any spiritual care which might make the other uncomfortable. In order to satisfy their own needs for spiritual conversation and prayer,

these employees have formed their own private network where prayer and spiritual talk are encouraged.

The very ambiguity with which hospice defines spirituality and spiritual care allows for this open resistance to the prevailing "Uber-ecumenical" culture. Although the presence of the Christian counterculture within the ecumenical culture is not celebrated, it is clearly tolerated, a true affirmation of the reality that hospice staff lives up to their commitment to tolerate people of all faiths. The presence of both groups also ensures that hospice is open to patients and families from all groups. The staff members from the Christian counterculture are quick to ask about spiritual causes of pain within team meetings. During announcements, they might ask the rest of the employees to "keep in your prayers" a coworker who is ill. The staff from the ecumenical culture are quick to caution against over-representation of hospice as a Christian organization and they might call a fellow staff member when they become too religious in their spiritual expressions. Tape 22 for example states, "One day, I told [another co-worker] about something that I had said. I said something, and every once in a while, she'll catch me and she'll say, Tape 22, that's too fundamentalist. {laughter} It's just so funny…There are times when I'll say something in the group, I'll say, 'Some people feel this way,' and she'll say 'I don't.' And it's okay. This exchange is just as good as any other because we have a great deal of respect with one another…It really is quite funny. This is not always easy."

Reflections

While not always easy, CCH illustrates that it is clearly possible to prioritize

spirituality in an organization, even a diverse organization. In Mayburg and Oakville, we see two different offices trying to meet the challenges presented by the acceptance of the spiritual within an organizational setting. These offices operate from two different presumptions about spirituality in their organizations and communities. In Mayburg, unity of belief, particularly Christian belief, tends to be the guiding presumption and public and staff prayer are designed to meet those needs. Although the Mayburg staff expresses a willingness to meet the needs of patients and families from all spiritual traditions, this tends to require an adjustment of their current practices. To date, the Mayburg staff has not had very many patients with non-Christian spiritual belief systems, so they have little experience adapting their public performances even though they have learned to adapt their patient care performances in individual settings, as will be discussed in the next chapter.

In Oakville, a diverse public and staff are presumed and forethought is given to possible discomfort and disagreement; thus, public and staff prayer performances are designed to be as inclusive as possible and the strategic use of ambiguity is one mechanism through which this is accomplished. Unfortunately, this very ambiguity becomes a source of discomfort for some employees and the sought after unity is not always found. In addition, the heightened awareness of spiritual differences at Oakville makes spirituality more of a target of conversation and potential conflict. However, in the end, it seems that the graceful manner in which hospice employees deal with one another allows them to continue to operate in a way that allows both groups to find fulfillment of their spiritual needs at hospice. In the next chapter, we turn our attention to

spirituality in interpersonal relationships at hospice as we examine the management of spirituality in the care provider – care recipient relationship.

CHAPTER IV

THE INTERPERSONAL DISCOURSE

I remember this one patient that I had, I had called him and said I was going to come out and give him a bath. And he said, "I don't want a black woman." I said I would just come out and talk to him and see what was going on. I remember the first day I went out there and he was sitting on the porch. I told him I was the care aide and come to give him a bath. He said "no one's ever seen me without my clothes on. Only two women have ever seen me, my wife and my mother." I said, "OK, that's cool, I don't have a problem with that. What we can do is when you're ready to take a bath, just go into the bathroom and wrap a towel or a sheet around or whatever and get in the shower and I'll give you the soap and whatever and you can do it that way. I can give you whatever you need and you can go in and do what you need to do and call me and I'll come in and see that you're OK." So we just sat and talked, I could tell he was kind of, he didn't want me to come.

So the next time I said "we're going to try it today" and he said "OK, now you just step outside." I said "OK, I'll step out and won't come in till you call me." Got his clothes off, I went in and gave him a little soap and everything. He said, "now don't look at me." I asked, "where are your towels?" "They are right there in the closet." He had forgotten to take his towel so I took the towel to the bathroom, handed the towel to him behind the curtain and he dried himself off. He came out and I asked, "how do you feel?" He said, "I feel much better now". I said, "OK good, that wasn't so bad was it? OK, I'll you see you."

I guess I was supposed to see him three times a week or so. This went on for a while then I could see he was getting weaker and weaker. Then he said "OK you can come in the bathroom with me this time." I went in the bathroom and left the door open, he said "OK I'm done" I gave him the towel and he asked if I could dry his back so I did, I dried his back. Then he said, "you know what, you're not such a bad person after all." I said, "well thank you, thank you".

After a while when I would call and tell him I was coming, by the time I got there I could see where he'd been sitting where he had a shoe, pants, shirt all the way to the bathroom. And I'd go in and say "how you doing today" and he'd say "everything's fine." He got to the point where he was just walking around just naked as a jaybird. He said, "you know I've never done this before never ever, you're the first one, you're the last one." That really made me feel good to know that I went from being that other person to being his closest friend.

He died, I think, he died at his son's home, I think, not too far down the road, he died there. But he wasn't like an invalid, you know, like in a bed or whatever. I think I went to see him a day or two before he died, and I remember him barely opening his eyes and he gave me just this little smile that says, "I'll see you later." It just broke my heart because the thing that we had gone through and to see him transformed from being this whatever gruff person to being just my friend. We were really tight. When he said, you know, "no other woman's ever seen me," that made me feel special. That was one of those things that made me love being a care aide so much because some of them they would really fall in love with you, you know. And you'd be their friend, their buddy, their

confidante, you know. They would tell you things that a lot of them that would tell me this that and the other. "And have you told your daughter? No." That made me feel special to know that this person and I have something that nobody else knew. And a lot of them said nobody else knows and nobody else will know.

In this chapter, I answer research questions four and five as I examine communication about spirituality in care provider and care recipient interactions. We begin with this beautiful story told by a long-time CCH care aide because it illustrates the philosophy of care at hospice. As discussed in the previous chapter, care at CCH is all about patient comfort. Care aides, nurses, social workers, and other hospice staff constantly adapt their care practices to meet the needs and comfort levels of their patients. In order to meet the needs of their patients, hospice staff members develop relationships with patients and their family members. The provision of all care, including spiritual care, is then guided by a relationally developed knowledge base of patient needs and desires.

Of course, as the opening to this story illustrates, developing relationships with hospice patients and determining how to make them most comfortable is not always easy. Often there are obstacles and challenges to be overcome. In this case, the patient's discomfort with the care aide's race and gender presents an initial obstacle and she must determine the most appropriate response. Initially, it might seem that finding a white, male care aide to look after this patient might provide the most comfort. However, this solution is both ethically and practically problematic in a hospice where all care aides are female and many are black. In addition, as the end of the story illustrates, the patient

and the care aide would both have lost out on a beautiful, compassionate relationship which ultimately brought the patient great amounts of comfort in his final days.

This story illustrates several dialectics that care providers continually face in all aspects of their relationships with care recipients including the communication of spiritual care. First, the care provider must consider the patient's best interests and determine whether those are best met by *following* along with the patient's own initial understandings of how care should be provided (in the story above by someone other than a black, female care aide) or *leading* the patient to a new level of understanding that might allow the care provider to meet their needs. Related to this leading-following dialectic are questions of expertise in the care provider- patient relationship. Certainly, patients know best how they want to live and die and are the experts when it comes to their care. At the same time, however, hospice workers are also experts. By virtue of their career experience, they have special knowledge about the death and dying process that might suggest different (and possibly better) care interventions.

Underlying these dialectics is the reality that care providers and care recipients may come to the care relationship with different world views and different understandings of the death and dying process. In terms of spiritual care, hospice workers and patients might have different understandings about the ultimate meaning of death and dying, meanings which suggest vastly different interventions of care. In this chapter, I examine these dialectics particularly in terms of spiritual care as we look at the role of spiritual talk and spiritual meaning making in the care provider patient relationship. I begin by reviewing the previous literature on organizational dialectics and

management strategies. Next, I examine the contradictions that occur at hospice and examine how these dialectics are created. Finally, I answer research questions three and four by demonstrating how care providers manage these dialectics in their communication with patients.

Dialectical Theory

In recent years, organizational communication scholars have begun to focus on the organizational tensions and contradictions that are an everyday facet of organizational life (Apker, Propp, & Ford, 2005; Ashcraft & Tretheway, 2004; McGuire, Dougherty, & Atkinson, 2006; Papa, Singhal, & Papa, 2006; Poole & Van de Ven, 1989; Stohl & Cheney, 2001; Tracy, 2004; Trethewey, 1999). These scholars posit that tensions, contradictions, dialectics, and paradoxes are a normal part of organizational life that can never be eliminated, but can be managed. The focus of this work is to understand the tensions that organizational members experience and to explore which management strategies might be most beneficial for organizations and their members. In following with this line of work, I use dialectical theory to explore the tensions experienced by hospice workers in providing spiritual care.

Dialectical theory was developed in the communication discipline by Leslie Baxter and her colleagues to explore contradiction in personal relationships (Baxter, 1988, 1990; Baxter & Montgomery, 1996) and has been shown to be useful for exploring organizational communication as well (Apker et al., 2005; Papa et al., 2006; Tracy, 2004). Dialectical theory has four main components: contradiction, change, totality, and praxis (Baxter & Montgomery, 1998).

The most central component of dialectical theory is the concept of contradiction. Contradiction refers to “the dynamic interplay between unified opposites” (Baxter & Montgomery, 1998, p. 4). Contradictions are thus inseparable from one another, one cannot understand a concept in the absence of its opposite. Hence, dialectical tensions always exist simultaneously. For example, in the medical field, nurses may simultaneously want to have close relationships with their patients and retain a sense of distance in order to provide appropriate care and manage their own emotions (Apker et al., 2005).

The second central component of dialectical theory is the concept of change. The manner in which relationship participants manage and experience dialectical tensions changes over time. In fact, many scholars argue that it is the very presence of dialectical tension that allows for and encourages change within relationships (Montgomery & Baxter, 1998). Third, dialectical theorists suggest that contradictions do not occur in isolation, but along with other contradictions. This interconnection between contradictions, called totality by dialectical theorists, suggests a need to study both the embedded nature of contradiction and the manner in which contradictions are interrelated (Baxter & Montgomery, 1998).

Finally, dialectical theorists direct our attention to praxis, the manner in which dialectical tensions influence relationships and the management strategies used by relational actors to manage these tensions (Baxter & Montgomery, 1998). This notion of praxis is multi-directional, in that as actors make choices to manage dialectical tensions, they create, alter, and recreate both the relationship and the dialectical tensions that act

upon it. Dialectical tensions can be approached in a variety of praxis patterns, some more functional than others. For example, Tracy (2004) found that corrections officers managed organizational tensions through a variety of mechanisms including: selection, source splitting, attending to multiple goals simultaneously, and withdrawal. Following Baxter (1988), Tracy suggests that reframing organizational tensions as complementary may result in more satisfaction than resolving tension by selecting one pole or withdrawing from the relationship.

As illustrated in Chapter III, bringing together spirituality and hospice care is a tension filled experience. Hence, it seems useful to apply dialectical theory to bring our attention to the manner in which hospice workers experience and manage these tensions in their relationships with care recipients. In this chapter, I focus particularly on the leading-following dialectic faced by hospice workers. I begin by exploring the nature and source of this contradiction. Next, I focus on praxis and explore the management strategies hospice workers use to negotiate this dialectic.

The Leading-Following Dialectic

Hospice Workers as Followers

At hospice, patients and families are viewed as care experts and hospice workers as novices. During volunteer training, the CEO shared a story illustrating this hospice philosophy. The story was about a group of staff members walking through a hospital. The story begins as the staff members enter a room and see a husband caring for his wife. He puts a fan at the bottom of her bed and wipes her face with water to keep her skin moistened. The staff members note this and then walk to the next room where they

find another wife to caring for her husband. In this room, she puts a scarf over the lights because their brightness hurts her husband's eyes. The staff members make another note and move on to the third room where they find an elderly man wrapping newspapers in towels. He then places these under his wife's ankles and knees to protect her paper thin skin from the bed. According to the story, the staff members then go back to their offices, they put on their badges and they collect together their degrees. Then they recreate the stories from the families, go to other people, and sell them as medical news. The staff members put big words on all the procedures that the families had already known. They would go back out into the hospital, enter rooms and say, "we suggest that you put something over the light, perhaps a scarf, or install dimmer bolts, to protect your loved one from photophobia." Next, they began to recommend expensive sterile positioning pads, which serve the same purpose as the rolled up newspapers. In concluding this story, the CEO states, "We learned and we still learn every day from the families." This story clearly places patients, and especially families, as key knowledge holders in the care provision relationship.

Because family members are the experts, hospice workers must learn from them how to meet their needs, especially when it comes to providing spiritual care. In order to accurately respond to patients' care needs, hospice staff members listen carefully to patients' stories and pay close attention to nonverbal communication. The CEO teaches this as a process of "walking the stepping stones." He states,

> I've said, "People lay down the stepping stones that they want you to walk." So when you walk in the house or when you pull in the driveway and there is one of

> those bird bathtubs and it has Madonna in the middle of it, you have a clue, you have your first clue. Then they will use vernacular. They'll start saying, "Oh I'm glad you are here. You are just like the Holy Father or the Holy Mother" and this or that. So, and it is not only the religious terms. They will lay down and say things and you, your responsibility is to listen. And then to, they'll give you one, two, or three and you venture out on one and reflect it back to them and then you can watch them because they'll say "That's right" or they will listen more or you will see them pull back. It is having the ability and certainly questioning is part of it, but a very small part of it. It is having the ability to listen, to understand and to access, in what spiritual potion, recipe do they have and then are you smart enough to take your stuff and package it that way. Then you've really demonstrated responding.

The hospice CEO teaches this philosophy to professional care providers, and the hospice chaplain teaches the same philosophy to volunteers. During volunteer training, we were instructed in, and provided a handout of, the "Three H's" of spiritual care: "Hang around, Hug 'em (if they are open to being touched) and Hush." "Hanging around" entails spending time with patients, developing a relationship with patients, and attempting to connect with them on a surface level. The bracketed caveat after "Hug 'em" clearly illustrates the need to first determine the patient's wishes. Finally, "Hush" is a reminder that most of the job of spiritual care is accomplished through listening to the patient.

This philosophy of beginning with the patient's needs is guided by an understanding of spirituality as both potentially helpful and potentially harmful. Certainly, spiritual meaning making can be important in the face of death and spirituality may be a powerful source of coping. Tape 44 states, "I think we try to acknowledge spirituality because you realize that it is a source of energy, it is a source of coping." Unfortunately, spirituality can also be used as a source of judgment and condemnation. It is the fear of the latter that worries the CEO and affirms the need for a strong organizational rule regarding spiritual care. The following story, shared by the CEO about the firing of one chaplain, illustrates how spirituality can be a source of harm.

> The wife knew that the man [the patient] had an affair 20 years ago in their marriage, but they never really talked about it. Before he died, she wanted him to cleanse his soul and she wanted him to confess to her that he had done that. She kept weighing on the chaplain to advise him and make him confess so he wouldn't go to hell. Finally, the chaplain gave in to that and said, "You must confess your sin to your wife or you will go to hell." The man, on his death bed, called me and said, "Get this person out of my home." And I did and I called that person up and fired them. I said [to them], "You don't do that. "Who in the hell empowers you to say if someone is going to hell?" It is no different than anything else. Families and people will use economics on each other, they'll use guilt on each other, they'll use lies and domestic violence on each other. They use intimidation in terms of spirituality. You'll hear it, you'll always hear it, "God always takes the good ones, but at least he's at peace with the Father." People

> can do all things in a very short period of time. People will use spirituality to their own ends, you know.

In sum, CCH's organizational rules pull care providers toward the following side of the dialectic. In some circumstances; however, the stepping stones may not be present and care providers are forced to adapt. In order to provide spiritual care, they might have to lead the patient. Care providers may also be pulled toward the leading side of the dialectic by their own spiritual belief system or by the patient's family members. In the next section, we examine the factors which pull hospice workers toward the leading end of the dialectic.

Hospice Workers as Leaders

On this side of the dialectic, hospice workers become the experts in providing care. While family members might be experts in their own individual circumstances, hospice workers are experts when it comes to the death and dying process. In a world in which no one likes to talk about death and dying, this expertise can become crucial to families at life's end. In fact, many hospice workers suggest that education is the most crucial part of their job. At intake, hospice workers spend significant time reviewing a handout with families about all of the signs and symptoms of the dying process. By going through this handout, hospice workers hope to normalize the dying process for patients and family members, but in this process of information dissemination, they also establish their expertise and establish a sense of leadership in the relationship which can have a very calming effect on patients and families.

Hospice workers are clearly experts in the medical management of the dying process. They know what types of interventions bring the most comfort care and which medications work best for particular diseases. However, hospice workers' expertise is not limited to the technical, medical management of the dying process. Hospice workers also have extensive knowledge about the spiritual and emotional processes of both patients and family members and they may find themselves called to lead in these areas as well.

One area in which CCH workers may have to lead families in is facing and dealing with issues of death and dying. In talking about death, Tape 29 states, "It's like the elephant in the room. Everybody knows it's there, everybody can see it. It's very, very obvious but nobody wants to talk about it. I think the first thing that I normally see when I'm going in for the first time is fear. That's when I start talking about it. I do. That was hard to start talking about death but once you start talking about it, it's like they really open up." Many employees noted that this is particularly important when it comes to spiritual care, because if a patient isn't facing up to death, they are probably also avoiding the spiritual processing that tends to accompany the dying process. Many of the workers believed, and told stories to support this belief, that patients who had faced up to death and found some sort of "spiritual peace" had a much better death.

Also pushing care providers toward the "leading" side of the dialectic is the knowledge that patients may have a difficult time bringing up spiritual issues or asking spiritual questions. Tape 32 noted that many patients have visions of heaven or loved ones that have died, but don't talk about them because they are afraid that others will

think they are “crazy.” However, in this nurse’s experience, once the door has been opened to these discussions, patients often have lots of questions and stories and are relieved that they can finally talk about these issues.

Care providers may also feel called to lead in these discussions by their own personal spiritual beliefs. Tape 19 states, “I know I’ve accepted Jesus as my personal Savior because I believe without a relationship with Him you can’t enter heaven. I really believe without a shadow of a doubt that I’m saved and that’s where I’m going and I want to bring some more people with me…It’s important when someone’s dying that they have accepted that, or they know that no matter what they’ve done in their life if they would just call upon the Lord, He will forgive them. It doesn’t matter what they’ve done. He just loved us so much that He died so He wouldn’t have to live without us in eternity.” In this care provider’s view, death is a crucial decision point in which an individual’s eternal destiny is decided, and this care provider feels called to take action to do as much as she can to make sure the patient is going to heaven. Tape 19 states, “You start praying for them. You really hope that they will talk to the minister about that. If they have anger or guilt or anything like that, you really try to get the pastor or minister to come.”

Finally, care providers may feel pressured by patient family members to “lead” discussions about spiritual issues. Tape 2 states, “The part that was the hardest for me is having a couple of patients who have been atheists, and the family really wants them “fixed” before they die.” This pressure was also evident in the earlier story that led to the firing of the hospice chaplain. In sum, care providers’ own spiritual beliefs, their expert

knowledge of the death and dying process, and pressure from a patient's family may push them toward the "Leading" side of the dialectic while organizational rules and the hospice philosophy may push them toward the "Following" side of the dialectic.

Balancing these dialectical tensions in relationships is never easy. However, the nature of relationships at hospice make managing this dialectic particularly challenging. In hospice relationships, the imminent reality of death puts significant pressure upon these relationships. Patients, family members, and hospice workers alike may feel that time is literally running out, so they may be less patient in their intervention choices. In other relationships, we may operate as if we have the luxury of time, as if we can apologize later, or go back and undo our mistakes. Hospice worker – patient relationships do not have that luxury and hospice workers always operate under this pressure. In volunteer training, the hospice CEO took care to make sure all volunteers were aware of these issues. He stated, "You can make a mistake with medicine, you can bruise someone during catheterization, you can misdiagnose a decubito. You can even drop them on the floor when you're moving them to a commode or something and those things happen and there is a comeback, there is a cure, there is a resolution to that, but, if you screw up someone's spirituality in the last few hours of their life, you've messed them up for eternity and that is unforgivable…the greatest mistake a provider in this organization could make is to do that." Nearly these same words were repeated to me by other employees suggesting that the CEO includes this teaching in employee training as well as volunteer training. As we move forward in examining these management

strategies, we need to remember that for all the participants involved, these choices may literally feel as if they are about eternal life and death.

Managing the Dialectic

We turn next to the strategies care providers use to manage these dialectical tensions in their communication with patients and families. Data analysis suggests three main techniques for managing these dialectics. First, care providers may select one side of the dialectic and deny the other. Second, care providers may use processes of segmentation and spiraling inversion as they vacillate between the two poles of the dialectic. Finally, care providers may attempt to transcend the dialectic and manage both poles at the same time.

Selection and Denial

One common way to manage organizational or relational tension is to choose one pole and operate as if the other doesn't exist (Baxter and Montgomery, 1996). A small minority of hospice workers chose this management strategy. One hospice volunteer always chose the strategy of leading patients by offering to pray with them. Tape 15 states,

> One volunteer in particular, David, he is a retired missionary and he is just so sweet and sensitive. He never leaves the home without asking a family if he can have a prayer with them. Now, regardless of what religion you are, most people say, 'Oh I'd love for you to pray for me.' Most people really want prayer, so he will pray for them, for their specific needs. And many times that opens the door

for either a visit from the chaplain or just a dialogue about some spiritual things that people weren't interested in talking about or didn't know how to bring it up. In this case, the "following" pole of the dialectic is de-legitimized for Tape 15 because the underlying cause for the organizational philosophy of "leading" – the fear that bringing up one's own spirituality without waiting for the leading of the patient will be offensive – is unfounded. This quote suggests these fears are unfounded for two reasons: the volunteer's "sweet and sensitive" nature and the fact that "regardless of what religion you are, most people say, 'Oh I'd love for you to pray for me.'"

One care provider was much more comfortable with the "following" strategy and her own personal experience combined with the organizational mandate led her to deny the need for any leading. Tape 32 states, "I really don't get into that because I don't really know what everybody believes. I'm not going to overstep bounds or anything like that I'm just there to reiterate how they believe and make sure they're comfortable with all of that. I'm not there to throw something new at them that they aren't familiar with. People are so funny about religion anyway. They want religion but they don't want something pushed upon them. It's got to come from within." Thus, this care provider will only follow the clear lead of the patients. In her opinion, leading, particularly in terms of spiritual care, would be futile for religion and religious change has to "come from within."

Segmentation and Spiraling Inversion

A second method for managing these dialectics is by switching between leading and following depending upon the situation, the time, or the topic (Baxter &

Montgomery, 1996; Tracy, 2004). Segmentation involves choosing one strategy for one topic area or individual and the opposite strategy for another. For example, some care providers would lead during discussions about medical issues, but follow during discussions about spiritual issues.

Another method of segmentation was to lead the family, but to follow the patient. This strategy was common in managing reactions to patients' visions. During interviews and in the course of team meetings, I heard many stories of patients seeing visions as they were nearing death. In the analysis of field notes, 22 of the 110 patient stories told relayed an incident in which care providers witnessed or discussed visions with patients or family members. In these cases, care providers would always follow the patient. When patients said they were seeing deceased family members or images of people in white, care providers would encourage them to share the visions and ask for more information. While it was easy to follow the patient in affirming these visions, often the family had to be led to be supportive. Tape 35 states, "I don't think families should go, 'No, that's not Aunt Ruth over there, that's the lamp.' I think if they're there and they are saying, 'Ruth's over there on the corner,' well then we should say, 'What's Ruth doing?' or 'What's she saying to you? What does she want?'" When family members were afraid of these visions, care providers used this expression of fear as an opportunity to educate family members about the dying process and offer them bereavement support and counseling to manage their feelings.

Care providers may also segment the dialectic by following the family, and leading the patient. The following story, delivered second hand by a nurse who had heard it from another nurse, illustrates this approach:

> There was another nurse that I worked with and she had been with Hospice forever…and really talked to me about the way some people have died and at the last minute have had conversions. She was talking about one time this guy that was dying, she said he was just horrible. It was just like he was scared and he would call the wife. He would hang on to her and say, "Don't let them get me" and it was like he was terrified. She said it was just scary and [the nurse] was saying that he has to believe in God so he can be at peace with this, and the wife said, "How do I do that?" She quickly told her, you know, that he has to believe that he can ask for forgiveness for whatever he has done. He did, and suddenly he had peace and she said he died like that night, you know.

This story also illustrates another common process of segmentation, segmenting leading and following in terms of initiating and engaging the topic of spirituality. These care providers waited for patients to lead by providing some sort of opening to discuss spiritual issues. Once patients had initiated spiritual conversations, care providers felt more comfortable in leading the content of the conversation to a particular solution.

In some cases, the patients or family members initiated spiritual conversations through direct questions. One technique for managing these difficult questions was to use them as an opportunity to have the chaplain come to visit the patient. The following story from Tape 18 illustrates this approach.

> Then like the patient I just lost this morning…the first time I went in to talk to her, she said, "I haven't been to church in a real long time, I read my Bible as much as I can. I realize that I'm not going to be here for long." She said, "The quality of my life has just gone downhill and what's the point? What's the point of staying?" So we talked a little bit and I said, "Would you like our Hospice Chaplain to come and visit you?" and she said, "That would be really nice."

This approach to answering the questions allows the nurse to share the burden of care with the chaplain who has more knowledge and experience in handling these issues.

A second technique for managing these direct questions was to answer them directly based upon the care provider's own spiritual understandings. One of the volunteers that I interviewed was directly asked one of these difficult spiritual questions and her response illustrates the use of this segmentation technique.

> About three to four weeks before he died, one day he was sitting there and we were watching the news. We didn't talk really about religion or God. You know you have to feel your way because we cannot bring it up, it has to be their idea. We can't bring up any kind of religion to a patient or promote our own religion to them. It has to be their idea. This man was 90 years old and had been in the Marines during World War II. This one day he was sitting up there and he said, "You know I wonder if God's going to hold us responsible for the lives we took during war time?" Well I blinked a couple of times and I said, "Lord I need help here." He didn't say anything else and I waited for awhile thinking there would be more of this conversation. Maybe there was some specific or particular

> incident he had in mind and he was thinking about. So I finally after, I guess, two to four minutes, it seemed like an eternity waiting for him to continue, and trying to get my thoughts together in some form to reply to him. I finally said, "Well Mr. Davis, I don't think God is going to hold anybody responsible for killing a person who was trying to take away their freedom of existence or their freedom of religion or anything that is really good." I said, "You know back in World War II Hitler, Mussolini and them, if we had not fought they would have over run the world. We would all be slaves. I don't think God wants us to be in slavery."

In some cases, reading nonverbal behavior and artifacts helps the care providers in choosing their spiritual care interventions. This was seen as particularly important when working with patients who are no longer able to directly communicate their wishes. Tape 18 illustrates the need to watch for nonverbal indicators in the following story:

> One of the first patients I saw when I came to Hospice was a lady that was in a nursing home that was pretty non-responsive, she stared. She was within maybe two days of dying. She didn't show any response to tactile stimulation, verbal stimulation, none, she just stared, but I looked on the wall. In nursing homes, the nursing home itself has a Catholic affiliation, but not everyone is of course. I looked on the wall and she had a Sacred Heart picture and the Blessed Virgin Mary and I'm Catholic so I went up close to her and held her hand and called her by name. I said, "You're Catholic and would you like to say the Rosary or at least say the Hail Mary with me?" and I began it and she moved her mouth and

> mumbled at the same time I did. Non-responsive, may mean, "I don't have anything I want to say," it may mean they're hard of hearing, it can mean a lot of things. But in this particular case, she wasn't connecting with what was going on around her and if she was, she couldn't verbalize it. This something was so strong for her that the Rosary brought her out, and there were other nurses around me when I was doing it, and they were real surprised because sometimes you touch on whatever it is [that will get through to them].

In sum, care providers might segment the dialectic by: leading in discussions about medical care and following in discussions about spiritual care, leading families and following patients, following families and leading patients, and leading in content of spiritual discussions but waiting for patients to lead in initiating discussions.

The next management strategy is spiraling inversion. Spiraling inversion involves an "ebb and flow" between each pole of the dialectic over time (Baxter and Montgomery, 1996). Most care providers spent the majority of their time following patients and family members, but special circumstances would cause them to choose to lead. Following was considered essential, especially in the early stages of relationship development. In telling of initial interactions with families, Tape 14 states,

> I would sit back and listen, quietly listen. I would sit in the corner and listen to this family and each person who was talking and the person who was going to be there every day or every other day or whatever. I would listen and kind of get a feel of how this person was going to react to this that or the other. Some of them, you could go meet them and it was really lively and it was OK, and with others

> you had to be very quiet. You'd hear things and just go. You could be bubbly one day and the next day 'I don't want to do this.' You have to adapt, and read the family; read the person you're going to mingle with.

This strategy of following demonstrates respect for the expertise of the family and a desire to provide the most comfortable care possible.

Tape 17 shares another example of how following the patient and simply being present to listen can have an incredible impact. In this story, the patient was a World War II Veteran who was trying to work through unresolved guilt. Tape 17 says,

> When [the patient] was five, his little three-year-old brother was in a swing… [The patient] went to lift it up and he lifted up the head and the baby brother slid out the bottom and into a fire. Wasn't his fault, he didn't do it on purpose. His brother survived and they lived close to each other for all these years but that was one of the guilt things he was dealing with. "Why was God so good to me? I did this to my brother." Then he went through the war and all the people he was standing next to that got killed and why didn't he get killed. He was incredibly guilt-ridden; I couldn't get through to him that he didn't have any reason to be guilty. His brother had forgiven him, God had forgiven him and he needed to forgive himself. Finally at the end, we were together four or five weeks I guess and finally there at the end he started to accept forgiveness.

In this case, simply being present and listening to the patient was enough to help him work through major spiritual issues.

Once care providers had developed a relationship with patients, they felt more comfortable engaging them in spiritual discussions. Tape 29 states, “Now the ones I do get closer to are the ones who believe like I do. You can talk more freely, you have a connection. That does play a part in this.” Tape 34 feels the same and states, “When you found a spiritual based family that can relate to what you are saying, that’s you know, a Christian family, it puts a little more into it because you relate better to them.” These care providers talked about reading the Bible to patients, praying with patients and engaging in several different types of activities. Once they felt the door had been opened to discussions of spirituality, they felt quite comfortable walking through. Even when patients and care providers came from different spiritual traditions, over time, the care provider would feel more comfortable engaging in discussions and learning from their patients.

In addition to time, in some moments care providers’ “intuition” might push them toward the leading side of the dialectic. Tape 9 tells the following story about giving direct advice about spiritual and family issues:

> I remember a couple, they were just the sweetest couple and the patient was the wife, and I had seen her several times. During these times, they had told me about their courtship and we did a lot of life review…Anyway, we had her for quite a while and I got to see her a lot, and her husband always stayed in the background but he was there, and as a social worker I had always been taught, you know, you never say “this is what you need to do.” You just lead them, like what are your options and what do you think, and that kind of thing. But anyway,

when she was dying and it looked like she had maybe a couple of more days, you know, I was visiting with him and he said he had a son that he did not get along with. He said he got along with his mother okay, you know, but he had been refusing to go and see her while she was sick, and he would keep saying he was busy and had an important job and could not get away. He was really hurt about it (the husband), and he said, “You know, he has not been of faith, and when I try to talk to him about God, he does not want to hear it.” I do not know what led me, but maybe God led me to say it, and I said, “This is what you need to do.” I said, “You need to just go ahead and call him, and tell him that Hospice says she is dying, and it probably won’t be more than a couple of days, and say if you want to say anything to her, you know, this is the time. Don’t tell him that you need him or anything like that, even if you do, don’t say it.” And I said, “When he is here, don’t say anything to him about God, religion, or anything like that because dying is a very spiritual thing.” His pastor actually lived a couple of houses down and was there a lot. The church members were there a lot, and he would see that, and so just let it go, and don’t say anything to him about it, just let it go. He called his son and he said “Oh no, I can’t come, I am not going to come, I have got meetings, I just can’t come.” [The son] said then that night he could not sleep. He said he tossed and turned and he tossed and turned, and finally he came at 3:00 in the morning. I did not find this out until a couple of months later, you know, I had heard that the son had come but I did not know quite what had happened. So when I saw the husband a couple of months after

> she died, he came to the office and I was walking down the hall and I saw him, he just came running up to me. He hugged me and said "You know you were right and it worked perfectly, and he [the son] now believes in God, and goes to church." It was beautiful.

In this story, Tape 9 clearly notes that such direct leading of the patient is a violation of her usual approach to following the patient's lead; however, her narrative suggests that this violation may have been authorized. The fact that "God led me to say it" clearly justifies the violation of the traditional social work ethic as does the final happy ending to the story. In addition, Tape 9 was clearly responding in the context of the relationship and already knew that the patient was a committed Christian who might welcome such a discussion. We turn next to management strategies in which care providers attempted to manage multiple goals simultaneously.

Managing Multiple Goals

Some care providers used creative communication strategies in order to transcend the leading-following dialectic. Several of these strategies attempted to open the door to spiritual processing, while allowing the patient to direct the content of the discussion. To do this, some care providers would ask patients questions that might indirectly open the door to spiritual issues. Tape 18 states, "You can always ask and you say it in such a way that it is not pushy. What is it that you need? What do you want to tell me about how you're feeling right now? ... Most everybody lets their hair down and they'll tell you what they need. They'll tell you that you bring joy to them and they sometimes pray with you." By asking these open ended questions, care providers lead by

providing an opportunity to bring up spiritual issues, but they then allow the patient to lead the content of the conversation in any direction they desire, spiritual or otherwise.

A second strategy in which hospice workers helped lead patients in processing their spiritual issues without leading in terms of content was to answer patient's questions with more questions. Tape 2 illustrates this technique:

> I had a minister on services…He had ALS, which is terminal, there is no cure, but he had his whole congregation praying for him and they were praying for a miracle. The wife knew he was going to die, the wife knew the stages of the disease progression, and he just refused to acknowledge that. So they sent me out there to address these end-of-life issues with him. So the way I handle it, I did not know what I was going to do until I got there, and it was so "What if what you have planned is not really what God has planned for you? What is this isn't really the way it is going to go". What have you done to prepare for that? So what is your plan "B"? We just kind of took this back a step and I think faith and hope and all those things are wonderful things, and you should keep praying and yes miracles happen, but what if it really is your time? How do you make sure your life is taken care of? So you turn it into more of a hands on type of thing….Those kind of things, you kind of go where they are. I do not get into things like I don't pray with the patients and I do not disclose a lot of personal stuff as my family has been all over the place with religion, denominational affiliation, and stuff like that. That is just kind of not my style. It depends on what the situation is. Someone will ask me what I think or I believe like "Why do

> you think this is happening to this guy?" You get some of those and that is kind of a question you just cannot really answer. We just don't know, none of us know when it is our time, that kind of stuff.

By responding to the patient's and wife's questions about the dying process with more questions, Tape 2 was able to deflect the conversation away from Tape 2's personal beliefs and focus on the beliefs and concerns of the patient and family. In this technique, the care provider assumes the leading role of processor or counselor, but does not give direct advice or offer answers. In this case, the care provider is the expert in terms of process and the patient the expert in terms of content.

The strategies of segmentation, spiraling inversion, and managing multiple goals capture the fluid notion of care provider-care recipient relationships and allow for significant adaptation to different circumstances. Although this adaptation appeared very comfortable for some care providers, adaptation was very difficult for others. In large part, managing the dialectic seemed easier for care providers when the leading-following tension revolved around different needs between patients and family members or around technical or emotional issues regarding death and dying.

However, there were times in which there was a disjuncture between a care provider's beliefs about his or her spiritual role and organizational roles. This created a paradox in which to obey the dictates of one role was to disobey the dictates of another. Dialectical tensions become pragmatic paradoxes when individuals hear them as double binds (McGuire et al., 2006; Tracy, 2004). The tensions faced by one Christian nurse caring for an Atheist patient illustrate how the hospice injunction to follow the patient

can become oppositional to the Christian dictate to proselytize, to lead people to Christian faith. Tape 1 relates the story that had been shared with her by another nurse,

> [The patient] wasn't religious. He didn't want to see the chaplain, and I remember that nurse giving a report when he died. She went there, and he said, "It's hot, my beds on fire. Its hot, it's hot, it's hot. The Devil's in here, it's hot, it's hot." That just for ever sticks with you because he, of course, the nurse who was there couldn't see anything. But he was just like, "It's hot, it's hot, and it's hot. It there's fire under me. There's fire under my bed." This man had a real bad history, you know, he beat his kids. I know it's just like gosh, those stories they do stick with you. While so yeah, it does get emotional. Not that you want to say where you're going because nobody really knows but you know, you could know.

The person who relayed this story and the nurse who originally witnessed the experience were both Christians. For them, this story was clear evidence of the reality of hell. To manage the discomfort brought by this negative vision, the nurse provided the patient with more morphine to ease his pain.

In this reaction, the nurse stayed firmly in her organizational role at CCH. Her feeling was that the man had clearly expressed his wishes by declining the hospice chaplain and she felt bound to follow that request. Her CCH nursing role suggested that the best intervention for an atheist patient was not a spiritual intervention, but rather a medical one. While this solution was clearly justified when interpreted within the hospice rules, when she interpreted her decision later according to her spiritual belief

system, the nurse experienced significant distress and she went to her Christian friend for affirmation and social support. This story demonstrates the difficulties that care providers can have meshing their own spiritual belief system with organizational dictates to follow patients and use ambiguous communication in order to avoid offending anyone.

In summary, hospice workers react to the leading-following dialectic in four main ways: selection and denial, segmentation and spiraling inversion, managing multiple goals, and interpreting the dialectic as a paradox. Certainly, these praxis patterns have both potential benefits and drawbacks for both care providers and care recipients. When hospice workers select the leading pole of the dialectic, they are assured that the topic of spirituality will be brought up in the care relationship, but they run the risk of alienating or offending patients. When hospice workers select the following pole, they are less likely to offend patients or family members, but they may not provide the appropriate opening or encouragement for patients who would like to discuss spirituality, but do not know how to broach the topic.

In addition, these praxis patterns may affect the care providers. Some employees are comfortable selecting one pole of the dialectic and denying the other, but other care providers, such as the nurse working with the man whose bed was “on fire,” feel that by choosing one pole over the other, they are betraying a vitally important part of their identity. We all play many roles in our lives, and when the dictates of these roles come in conflict with one another, we may feel significant distress, both personally and professionally (Apker et al., 2005).

The strategies of segmentation, spiraling inversion, and managing multiple goals provide a more nuanced approach to managing spiritual discussions which seems to allow care providers more freedom to adapt to particular patient circumstances. By using these strategies, care providers transform potentially contradictory tensions into complementary ones. Although this approach seems more beneficial to care recipients, it is not without challenges. It takes significant time and energy to develop relationships with care recipients and spend the time necessary to get to know patients and then choose communication strategies to adapt to their needs. This approach may become increasingly difficult, particularly as CCH faces an impending budget crisis that may increase care providers' patient loads. In addition, developing close relationships with patients can put significant stress upon care providers, for the closer they become to patients and families, the harder it becomes to let go when the patient dies. In the final chapter of results, I turn my attention to these issues and examine the manner in which care providers experience and manage these tensions internally as they bring together their spiritual and professional selves.

CHAPTER V

THE PERSONAL DISCOURSE

"I often think, I feel like I died and went to heaven because I have a job where I do not have to leave a big hunk of myself at home."

CCH employee talking about the role of personal spirituality at work

"Of course, as a Christian, religion is extremely important. We know we are not supposed to be a Christian with the patient…we are limited in what we can say and do, but we can always be a, um, no one can ever stop me from praying for people."

CCH employee talking about the role of personal spirituality on the job

"You have to pray. You really have to pray to make it through a day. You've got to have faith."

CCH employee talking about the role of personal spirituality and stress management

As the first of these quotations demonstrates, hospice work feels like an authentic expression of spiritual identity for some employees. Working at hospice feels like coming home to a place where all of oneself can be expressed through the job. For other employees, however, hospice is a place of limitations, a place where one's full identity cannot be publicly expressed. For these employees, presenting a work identity in concert with the preferred hospice identity is more of a struggle. In this chapter, I turn my attention to the process and outcomes of these identity struggles as I consider the

final research question, “How does the structuration of spiritual care policies affect care provider motivation, coping mechanisms, and the experience of stress and burnout?” Underlying this question is the assumption that organizational discourse creates expectations about the appropriate motivational structures and coping mechanisms for hospice workers. In this chapter, we examine the preferred hospice worker identity suggested by organizational discourse and explore how employees respond to the demands of this identity. This analysis demonstrates that the underlying assumptions about spirituality at hospice can create an overly individualistic culture which prevents employees from connecting to each other in a manner that might help them to avoid stress and burnout. I begin by reviewing the preferred hospice identity.

This preferred hospice identity, what the “self” should be in the workplace, is created and maintained by organizational members’ discourse (Tracy & Tretheway, 2005). The last two chapters have given us a good picture of the preferred hospice identity, at least in terms of performances related to spirituality. At hospice, the preferred self is a gracious servant. In terms of spiritual care, the ideal hospice worker is gracious - a perspective taking chameleon who does whatever is required to meet the needs of patients and their families. The worker is expected to “meet patients where they are” whatever the worker’s own belief system might be. CCH management also demonstrates the style in which this identity is to be performed. In order to appeal to as many patients as possible, hospice employees are to use strategically ambiguous communication when it comes to discussions of spirituality with patients and their families. They are to follow patients and refrain from leading them even when the care provider’s own spiritual

beliefs might suggest otherwise. Underlying this approach is the assumption that there are a wide variety of acceptable and viable modes for spiritual sense making.

In order to ensure that hospice workers and volunteers know these expectations, hospice management tells stories about fired chaplains, and in volunteer training, the chaplain tells us, “If you are the type of person who tries to convince everyone you meet about your faith, you probably need to go elsewhere.” These comments suggest that employees who do not perform this preferred identity might face potentially dire consequences, such as losing one’s job.

Similar dire consequences might result if employees fail to live up to the latter half of the preferred identity – the service identity. The ideal hospice worker is committed to being a servant and finds joy in the giving of oneself for others. Tape 44 states, “If you’re here, you are here to serve. If you are not, get the hell out. Um, it is a joy and an honor to serve. It is. If you haven’t figured out the replenishment loop, and we’ll try to help you figure that out, we really, really will, but after two years, if you haven’t figured out the replenishment loop- and the replenishment loop is, I serve and I feel good about serving and I feel kind and I feel gentle and I feel productive and so I serve. If you haven’t figured out the replenishment loop, there is not much I can do about that, you know, get on with it.” As this quotation indicates, the ideal hospice worker’s natural inclination to serve should protect him or her from the burnout and compassion fatigue that is often associated with hospice work. This suggests that employees who do feel such things need to find better individual coping strategies and if they cannot, they may not be meant for this type of work. In this chapter, I suggest that

the performance of this preferred identity often requires hospice workers to privatize their "real" selves and perform public spiritual work. This separation between the "real" self and the "fake" self can cause employees significant stress and emotional dissonance. This emotional dissonance is heightened by the pressure to continually perform as a "Gracious Servant." I begin by examining the performance of public spiritual work.

Public Spiritual Work

"Public Spiritual Work" occurs when employees perform or participate in spiritual rituals for external audiences. We have seen several examples of this in previous chapters, particularly in terms of patient care. For example, public spiritual work includes non-Christian employees praying with Christian patients and Christian employees refraining from sharing their faith with Atheist patients. Employees may also perform public spiritual work for the benefit of other employees. For example, Tape 25 attended a prayer meeting that made her uncomfortable for the benefit of other employees. The preferred hospice worker identity suggests that the "good" hospice employee will consider such work just another part of the job, no more difficult than giving a patient medication or taking a patient's blood pressure. However, when I asked CCH workers to talk about the role of their personal spirituality in day-to-day hospice work, several employees' suggested that performing this public spiritual work was not always easy. Further analysis of these stories suggested that the process and outcome of performing this type of spiritual work depended upon the workers' own understandings of spirituality. This analysis revealed two different ways of understanding spirituality and the role it should play in ones' work: spirituality as mystery and spirituality as

certainty. Those who viewed spirituality as mystery seemed much more comfortable with the display rules of the "Gracious Servant."

Spirituality as Mystery

Adapting communication about spirituality in particular contexts was largely unproblematic for those employees who believed that meaning could be found in multiple spiritual traditions. For these workers, the world of spirituality is a mysterious one. These workers agreed that spirituality could be a source of hope and comfort, but the exact manner in which spirituality manifested itself varied from individual to individual and the spiritual realm was much too vast for any one answer to life's questions.

For some employees, the comfort with a wide variety of traditions came from their own experience with a multifaceted spiritual identity. Tape 2 describes a spiritual identity cobbled together from a variety of traditions:

> I do not see myself as a very religious person, but I see myself as a pretty spiritual person, kind of interconnected and more alert, more aware of things. Some of this, I think, is associated with the work that we do… I have explored, and changed, and read, and moved around, and I have come to the conclusion (like I said earlier) I do not have to claim a denomination. I do not have to be a whatever. Before, I was a firm believer in Catholicism. When my dad yanked us out, we were Southern Baptist. Half of my family is Catholic. I like a lot of anthropology which is a big elective for me. I liked a lot of religious rituals and that kind of stuff. I sort of understand why people like Native Americans for

example who are primitive and have respect for mother earth. I think that is kind of where I am. I am bits and pieces of each one and they kind of make up me. Because Tape 2 has found meaning in such a wide array of spiritualities, he can empathize with a wide variety of spiritual perspectives. This spiritual journey has also included moments of doubt and disbelief, so he also empathizes with patients who are Atheist or Agnostic.

Other employees who viewed spirituality as mystery found personal meaning within a single spiritual tradition. For example, many employees described themselves as Christians and found great strength and hope in the Christian tradition. However, they also believed that Christians were called to accept and love people; thus, the hospice philosophy was a good fit with their own beliefs. In explaining a personal philosophy for working with patients with a different belief system, Tape 36 states, "They are God's children and God is the resource, and we are supposed to help them their way through their loss just like anybody else. That is how I believe and I am okay with that. We are supposed to greet people like they are and accept them that way. After all, that is what God does, right where we are." For this employee, then, supporting a wide variety of spiritual systems was unproblematic because it was her job as a Christian to serve and love all patients unconditionally.

In fact, these workers often had a difficult time with patients who professed a great deal of certainty about their own spiritual belief systems and expected that their care providers would have the same. Tape 2 states, "Some patients really want to know a specific such as "are you a Catholic, are you a Baptist?" and they really want somebody

just like them, and I do not feel like if fit into those categories very well." Instead of answering these questions, these care providers attempt to skirt around them using ambiguous communication that can be read as the patient so chooses.

Even in these cases, the underlying assumption that people use a wide variety of spiritual sense making mechanisms helped these employees to deal with those who had more rigid spiritual perspectives than their own. Tape 22 states, "There are sometimes people who are very strong in their beliefs and so they express them very strongly. And that degree of exuberance over spirituality can kind of jolt me a little bit. But probably not enough for them to notice. Again, I understand, that's really important for them." In these cases, employees maintain their certainty in mystery by explaining the patient's rigid definition of spirituality as one way of making sense of ambiguous world. In order to find some sort of common ground, these employees focused on the shared purpose of spirituality as a way to make sense of a frightening and unexplainable experience rather than the exact manifestations of spirituality.

For this group of staff members, the use of ambiguity serves two purposes. As has already been discussed, it can help to serve a wide variety of patient needs. In addition, ambiguity serves to protect the employee's own spirituality from outside scrutiny. For some CCH employees, spirituality is fundamentally a private experience and speaking in abstractions and ambiguities allows them to protect their privacy. This is essential because in these conservative, Bible belt communities, expressing the belief that there is no God or that there are many ways of understanding God can be tantamount to heresy.

Consider the following story about one non-Christian employee's experience visiting a college class to talk about the hospice philosophy. Tape 22 states,

> Every time I would go on campus to talk, I would get the same question. I would say to them hospice is a spiritual organization. We recognize people's spiritual beliefs. We feel spiritual. We feel like we have a higher mission but we're not a religious organization. We don't follow one religious path. [I would get the question], how do reconcile that when you are a very strong Christian? So, it was very difficult. It is always very difficult for some of the students who come from a very strong and traditional background to believe that, to understand that anything other than what they believe is true. I know I couldn't convince them, but I said, for me we have to accept where each person is.

This was not the only time that these employees suggested an awareness of possible negative community reactions to non-Christian spiritualities and their interview comments expressed an acute awareness of the potentially negative consequences of articulating an alternative spiritual view in a primarily evangelical, Christian environment.

In sum, the hospice approach to spiritual care aligned well with many employees' sense of spirituality. They viewed spirituality as an individual experience and often preferred to keep their own beliefs private. The manner in which these employees understand spirituality – as any philosophy that brings comfort – allowed them to respond to a wide variety of patient needs. We turn next to employees who had more

difficulty performing as “Gracious Servants” because their own understandings of spirituality precluded an adaptive approach to patient care.

Spirituality as Certainty

For employees with a view of spirituality as certainty, questions of meaning are found in a deep faith. There is one true God and expressions of self must always be consistent with this faith. For these employees, the assumptions underlying the preferred hospice worker identity were fundamentally problematic. If there is only one true God, one true way to find salvation in an uncertain world, then communicating in a manner that suggests that there are a wide variety of possible modes for spiritual sense making is unacceptable.

In this understanding of spirituality, CCH employees told a story of spiritual development in which they had been saved by a gracious God. Through total submission to this God, they found freedom and a way of life that gave them hope and guidance. Consider the story of Tape 5,

> I got married when I was 20. I started with a very spiritual mother-in-law. I credit a lot of my growth in that area to her. Looking back I know that God had this plan for me to marry this guy and she would be my mother-in-law and teach me and teach my children. It has been awesome and probably the time I was most spiritually involved. I was raised in the Methodist church. My husband was Baptist and there was just a little bit more emphasis on some things than I kind of had. We really did not study the Bible and that kind of thing in domestic terms. We got more into that kind of study and really learned more about that area.

> Well, I started seeing things in a different way. I always had prayed and God has always been a part of my life, but obviously my eyes were not open all the way. With the awesome responsibility of having children and your responsibility of teaching them, and worrying about their spiritual state, I talk to Him all the time as a mother because to me, and this is what I tell my kids, when I pray for them every day that if you want and stay okay with God and keep a good relationship with him and he is a part of their lives that nothing else will matter. It does not matter if they make the team or if they make the grade or make all the things that you set for yourself and that are important even. As long as God is at the top of their list, that is all I could have asked them for is that they have a good relationship with God.

In this story, God is the ultimate source of hope, safety and meaning. All good things are attributed to faith in God, as are the avoidance of bad things. God has been good and gracious in the lives of these employees, and they want others to be able to experience a similar sense of freedom.

This faith in God is particularly important at life's end for these employees believed in heaven and hell. Tape 29 states, "Some people when they die they have a look of fear on their face. That's scary. I do believe in a hell too." As discussed in the last chapter, Tape 29 feels that part of her job as a Christian is to "bring some more people with me" when she gets to heaven. In order to do this, she needs to reach out to nonbelievers and tell them about her faith or they will spend eternity in hell.

The stories that these employees tell about their work with patients suggests that the hospice experience serves as verifications of these beliefs. Tape 32, for example, states, “You can tell when a person has not met that spiritual plateau. They are more restless, they’re more fearful. The people that are okay spiritually are usually braver and peaceful. They openly have previously talked about dying most of them at some point. They always know then they want to die. They always know. The spiritual part of it is something that has to happen to them before they can have a peaceful death.” The earlier story of the patient whose bed was “on fire” was also commonly told by these employees as an affirmation of their beliefs about the afterlife. For these employees, working with non-Christian patients, especially Atheists or Agnostics, is difficult. In their work, these employees also see themselves as servants; they want to help patients die a good death. In their worldview, the way to find a good, peaceful death is through faith in Christ. Yet, the preferred hospice identity precludes talk about these issues unless it is explicitly invited by the patients.

Thus, these employees face a paradoxical situation – to be a good hospice employee is to be a bad Christian; to be a good Christian is to be a bad hospice employee. Fortunately for these employees, the majority of CCH patients are Christians, so most of the time hospice workers do not have to directly face this paradox. However, there are moments when working with an Atheist or Agnostic patient forces hospice employees to directly face these contradictions.

Analysis of these interviews demonstrated two different approaches for managing this situation. First, employees could leave the organization. As we have seen

with the firing of the chaplains, this may not always be a voluntary withdrawal; however, during the course of this study, I did come across one former hospice employee who quit because she wasn't allowed to share her faith with patients. Obviously, for some employees the conflict between these two identities was too strong and couldn't be managed in any way except withdrawal.

Other employees managed to alleviate these tensions by reframing their understanding of the situation. One of the most fundamental ways to do this was to frame their work at hospice as a response to God's calling. Consider the words of Tape 5, "I pray a lot about things. I feel like I just give my life, you know, all guidance to God so He was involved… So that is why I knew I was supposed to be here. I did not know why, I didn't know and still don't really know, but I knew from the very beginning that my life is here. So this was all due to God's guidance." When these employees felt tension with the restrictions placed upon them by hospice, they felt that God understood those restrictions would be in place and that they were bound to obey them even though this seemed oppositional to traditional teachings. That didn't mean that employees didn't challenge and push the restrictions placed upon them. These employees often stretched the restrictions as far as possible without fully violating them and they celebrated their ability to serve the Christian patients that came to hospice.

For these employees, following the display rules of the "Gracious Servant" requires significant effort because they feel the need to subordinate their own private beliefs in order to present the appropriate public face of the Gracious Servant. These employees experienced considerable emotional strain when they worked with patients

who were not Christian. Tape 19 states, “It’s real sad. You start praying for them. You really hope that they will talk to the minister about that.” Tape 20 adds, “It’s the families who are Agnostics or Atheists; sometimes they’re just not nearly as smooth a picture with those families. Lots of complications and you can’t help but wonder about the correlation there…It’s very sad when you see the families that don’t have any kind of faith basis in their lives. They struggle a lot more.” Tape 23 adds, “They don’t want to see the preacher and that bothers me. I wonder, ‘where are you going?’ that bothers me…I know there are people and they don’t believe and I think they are fools.” Employees found the strength to cope with this sadness through prayer. They prayed that the patients and their families would find some kind of comfort and prayed that they might be instruments of God’s work in providing that comfort.

In sum, performing as “Gracious Servants” was problematic for employees who viewed spirituality as certainty. They believed in one spiritual Truth and experienced stress and sadness in working with others who had not found the Truth. In order to continue to perform as “Gracious Servants,” these employees reframed their work as God’s work and turned to God for strength in difficult times. In the final section of these results, I explore more fully the impact of privatizing employee spirituality while simultaneously demanding employee’s frequent spiritual service and sense making.

The Costs of Privatizing Spirituality

This analysis suggests that performing the preferred hospice worker identity, the “Gracious Servant,” sometimes required employees to perform an identity that did not match their “true” self. For those who viewed spirituality as mystery, the “real” self had

to be kept private around those that might be judgmental of non-Christian spirituality. For those who viewed spirituality as certainty, the "real" self had to be kept private around those who might be judgmental of Christian spirituality. Certainly, there are benefits to this approach as a wider variety of patients may receive service and employees avoid uncomfortable conflict. However, there are also potentially negative outcomes.

The discourse at hospice calls for employees to privatize their spirituality with little critical reflection about the outcomes for hospice employees. This notion of holding one spiritual belief internally and performing another externally might be viewed as a kind of spiritual labor that is in many ways analogous to the more frequently explored concept of emotional labor. In Hochschild's (1983) groundbreaking research, she found that many employees perform "emotional labor" by managing their own emotional reactions, or at least their expression of emotion, in order to meet the dictates of management. For many of these employees, presenting a public, work self that was different from their private self caused uncomfortable feelings of emotional dissonance which could lead to emotional exhaustion and burnout (Hochschild, 1983).

This outcome might be especially profound at hospice as the discourse encourages employees not only to privatize their spirituality, but also their feelings of stress and burnout. Recall the CEO's dictates that the ideal hospice worker is to be a "Gracious Servant" who finds strength to serve in the joy that comes from serving. If an employee does not find a "replenishment loop," they are, by definition, not meant to be a hospice worker and should find a new job. This discourse suggests that if employees are

experiencing stress and burnout, the problem lies with them and not with the organization.

The topic of employee stress and burnout was a point of contention during my time at hospice. The week before I began my study, one of the employees distributed information about "compassion fatigue" at a team meeting in Oakville. Her goal was to encourage discussion of employee stress and burnout and consider ways in which these outcomes might be eliminated or at least better managed. In response to these handouts, the CEO challenged the idea of compassion fatigue. I later asked him to explain this response in our interview. He said,

> [The idea of compassion fatigue] is that after X amount of this, you just give up, you can't do it. You've cared too much, you've pronounced too many, whatever. So we are suffering fatigue. Um, if you were in the business of selling cars and you became the best salesman in the branch and you sold more cars than anyone else and it was your desire to do so and that was your job, are you not happy? Is that not what you intended to do? We are in the business of serving people, so should serving 100 be any different from serving 10? It is an excuse to not be productive. It is an excuse not to serve difficult patients; we have a lot of difficult patients. It is an excuse that we have to be more gentle to each other. I will be gentle when it is called for. So when a nurse has been on call for 30 hours and has had three really difficult deaths and the families were really dysfunctional, I'm going to be the first one that says, "Send her home, let her rest." But when someone says, "Oh my god, last week we had the hurricane, and then we had to

> take care of our regular patients and then we had nine new patients." And they don't like it, and I'll say, "Let me tell you a story about walking through the snow, about how we used to do it." And they don't want to hear that and I understand that, but if you're here, you are here to serve.

The idea that the ideal hospice worker would not get burned out was reinforced in a later training on stress management. During an in-service on burnout, the leader, another hospice employee, stated, "If you're basing your life on your talents and goals, you won't feel stress." This statement once again reinforces the notion that stress is an individual, rather than an organizational problem.

Unfortunately, stress was a problem faced by most CCH employees. Early in my data collection, few employees reported being stressed out, but as employees became more comfortable with my presence, they often talked about their frustrations with the organization. One of the most frequently mentioned problems was the lack of management support for employees feeling emotionally drained. Although co-workers did attempt to provide social support for one another, they were often too busy to find time to support one another and the organizational discourse encouraged the private management of stress and burnout.

In private interviews and the stress management in-service, CCH employees reported relying upon a wide variety of stress management strategies including: social support from family and friends, emotional detachment and reframing, gambling and shopping. However, the most common stress management tool mentioned in this study was the performance of spiritual activities. Certainly, these responses could have been

primed by the nature of my study, but the fact remains that many employees reported using spiritually based coping mechanisms. Prayer was one of the most common ways of coping with stress. Tape 14 states,

> When I started seeing the patients, I would always say a prayer before I would do whatever it was I was going to do. I would always say a prayer about all of the problems in the home. And a lot of the time when I would leave a home, I made it better, and at night when I would see my last patient, I would say "thank you Lord for letting me make a difference". I'd go down the highway or whatever and I'd say a prayer. That was my way of getting from point A to point B. For me, that was the only way that I could do it sometimes. Because sometimes I was sick as a dog and I'd pray and before I knew it the day was over and I would go home. Religion has helped; God has helped a lot with this.

Prayer was also very helpful in moments of uncertainty for it provided employees with a way to manage their feelings of helplessness in the face of very difficult situations. Tape 43 states, "It helps sustain me being here every day…I talk to God in a prayer and let Him know, 'OK, you got him [a deceased patient] or her up there now. Now help me get through this. Help me understand why this is happening." Some employees found strength in the belief that God provided answers to their prayers while others used prayer less as a tool to find answers and more as a time for quiet retrospection and centering. In addition to prayer, employees engaged in a variety of other activities that they classified as "spiritual." These included: reading spiritual books,

taking long walks, spending time in nature, meditating, and joining a community of faith.

The frequency with which employees turned to spiritual practices in order to regain a sense of equilibrium suggests that spirituality can play an important role in stress management. Unfortunately, organizational discourse about spirituality discouraged employees from truly connecting with one another around issues of spirituality, stress, and/or burnout. As we have already seen, The Hospice Workers' Prayer, management's attempt to encourage employees to feel spiritually connected to the larger hospice team, was just as likely to provide moments of disconnection. This forced some employees to seek social and spiritual support from one another in covert personal prayer meetings. Other employees simply accept the privatization of spirituality and the individualization of stress and burnout. Neither of these approaches truly challenges the underlying assumptions of the preferred hospice workers identity in a manner that might encourage employees and management to rethink organizational structures and policies.

In summary, the "preferred" organizational identity of the Gracious Servant can be problematic for employees in two ways. First, it may require employees to perform spiritual labor as they interact with coworkers or patients from a spiritual perspective different from their own. Second, the Gracious Servant identity silences talk about stress and personal spirituality which can isolate employees from one another and increase the likelihood of burnout. In the final chapter, I consider these outcomes further as I reflect

upon the relationships among personal, organizational, and interpersonal communication about spirituality at hospice.

CHAPTER VI

REFLECTIONS AND CONCLUSIONS

"I wanted a perfect ending. Now I've learned, the hard way, that some poems don't rhyme, and some stories don't have a clear beginning, middle, and end. Life is about not knowing, having to change, taking the moment and making the best of it, without knowing what's going to happen next. Delicious Ambiguity."

Gilda Radner

As I sit down to write this concluding chapter, I also find myself hoping for a perfect ending. I have read and re-read the preceding chapters in hopes of finding one gleaming thread that I can pull from them to tie this entire work together. As I tug at each thread, pulling on a dialectic here or a theme there, I find the entire tapestry threatening to come unwoven. So, I have decided to abandon the search for one certain, clear, unambiguous answer about the best way to talk about spirituality at hospice. Instead, this final chapter revels in "delicious ambiguity" and messiness: the messiness of spirituality, the messiness of communication, and the messiness of ethnographic research. Thus, this chapter is less an ending and more a brief moment of pause in which I consider the answers that I have found and explore the questions that still remain for future study. I begin by summarizing the previous chapters and briefly outlining the lessons CCH management and staff taught us about the messiness of spirituality and communication. I then offer theoretical and practical reflections linking these CCH lessons to previous research and suggesting how they might inform future research.

Finally, I conclude with personal reflections about the messiness of my own spiritual and professional research journey.

Lessons from CCH

The first three research questions brought our attention to the discourse of spirituality at hospice and the manner in which this discourse responded to internal and external demands upon the organization. At CCH, the high priority given to spiritual care was demonstrated by the low chaplain to patient ratio and the commitment to "spiritual care" written into the organizational mission statement. As suggested by previous research, spirituality was considered critically important for effective holistic patient and family care (Daaleman & VandeCreek, 2000; McGrath, 1997). However, this analysis demonstrated that community expectations, fundraising demands, government policies, and employee needs also influenced organizational communication regarding spirituality.

In response to these demands, CCH adopted the strategically ambiguous term "spirituality" and refused to firmly define a spiritual perspective (Eisenberg, 1984). The goal of this approach was to allow each stakeholder to interpret hospice's "spirituality" in a fashion that fit comfortably with his or her own perspective. This ambiguity also allowed for different public depictions of spirituality. In Mayburg, where the most pressing need was to appeal to the prevailing community values, public performances of spirituality included Christian rituals. In Oakville, public performances of spirituality were less common and more ambiguous in order to appeal to a more diverse audience. This chapter demonstrated that strategic ambiguity could facilitate the accomplishment

of the greater organizational mission while simultaneously accommodating a diversity of opinions among stakeholders and allowing organizational adaptation to different communities. Despite these benefits, this analysis also suggested that there may be drawbacks to the use of strategic ambiguity, especially with regard to spirituality. The analysis of employee reactions to the Hospice Workers' Prayer demonstrated that ambiguity was not always interpreted in the inclusive, comforting manner that management intended. For some hospice employees, the very notion of spiritual ambiguity was problematic and thus, they experienced discomfort and disconnection during the Hospice Workers' Prayer. This result has several interesting implications for the theory of strategic ambiguity that will be further developed in the section on theoretical reflections.

The second set of research questions also drew our attention to challenges presented by spiritual pluralism. This chapter incorporated dialectic theory as a lens to explore the process of spiritual care as enacted by hospice workers (Baxter, 1988, 1990; Baxter & Montgomery, 1996). Analysis of patient care stories demonstrated that care providers must manage the dialectical tensions of leading and following as they seek to comfort patients and family members. Pressures to follow came from organizational rules and the hospice philosophy while pressures to lead came from patients' family members, care providers' spiritual perspectives, and care providers' expert knowledge. This leading-following dialectic was managed through the processes of selection and denial, segmentation, and spiraling inversion. In some cases, care providers attempted to transcend the dialectic and manage both goals by leading the process of spiritual

discussions, but allowing patients to direct the content. Finally, some care providers experienced the dialectic as a pragmatic paradox causing them to experience significant role conflict.

The final research question pointed our attention to the relationships among the preferred hospice worker identity, care providers' spiritual beliefs, and care providers' experience of stress and burnout. This analysis demonstrated that the preferred hospice worker identity was the "Gracious Servant." Performing this identity occasionally required hospice workers to perform spiritual labor. Spiritual labor occurred when employees privatized their own spiritual beliefs in order to serve patients, family members, and coworkers by adapting to the ritual performances of another spiritual perspective. The results also showed that working at hospice led many employees to perform private spiritual labor in which they drew upon their personal spiritual beliefs to cope with the stresses of working in hospice. Finally, the analysis suggested that the privatization of both spirituality and stress could lead employees to feel isolated from one another and might increase the likelihood of burnout. I turn next to the theoretical and practical implications of these results.

Theoretical and Practical Reflections

Strategic Ambiguity and Spirituality

In arguing for ambiguity as a potentially effective communication strategy for organizational members, Eisenberg (1984) rejected a realist ontology and posited a socially constructed world in which meaning is "contextual and constructed" (p. 229). Building upon this philosophical grounding, Eisenberg and many others drawing upon

his theory (Contractor & Ehrlich, 1993; Leitch & Davenport, 2002; Markham, 1996), argue that strategic ambiguity can promote unified diversity. These authors suggest that individuals within organizations can find agreement and function effectively when organizational values are expressed at the appropriate level of abstraction. The CCH discourse of spirituality seems in many ways a textbook use of strategic ambiguity. Why then, we might ask, does it fail to achieve the desired result of individual agreement around abstract principles? Why does strategic ambiguity at CCH sometimes foster contention and conflict rather than collaboration and connection?

The problem seems to lie less with the correctness or incorrectness in CCH's use of ambiguity as a communication strategy, and more with the fundamental philosophy upon which the concept is based. When it comes to spirituality, the very notion of ambiguity is problematic for some individuals because they do not view the world as socially constructed. For these individuals, there is an ontological reality above and beyond our human constructions and any appreciation for relativism is antithetical to this ontological certainty. In a recent article, theologian Rosemary Radford Ruether (2005) summarizes the problems of pluralism and ambiguity for some Christians.[3] She states,

> Those with a strong sense of their Christian identity necessarily affirm this identity as exclusive of other religions. Strong Christian identity means knowing that Christianity alone is the true religion and other religions are false, or at least defective. By contrast, the more one is open to the possibility of truth in other

[3] My discussion centers upon issues of Christian identity and spirituality in this section because that is the most prominent spiritual tradition at CCH and in the surrounding communities. I do not mean to claim that Christianity is the only spiritual tradition that has difficulties tolerating ambiguity nor that this particular understanding of Christianity is shared by all those who would call themselves Christians.

> religions, the weaker one's own Christian identity becomes. Accepting truth in other religions means "watering down" one's sense of the truth of one's own faith, accepting a normless "liberalism" in which "anything goes" and "everyone has a right to their own opinion." (p. 29).

Ambiguity as a strategy, particularly as a strategy for facilitating spiritual care and meaning making, suggests that there are multiple answers to spiritual questions. As Ruether's quotation suggests, this pluralistic view is fundamentally at odds with some spiritual understandings.

I do not point out the tensions faced by these care providers in order to critique their belief systems nor to assess the truth claims of any spiritual tradition. I leave the debate about the truth claims of relativism and religion to the philosophers and theologians. Instead, I bring the tensions between ambiguity and particular lived experiences of spirituality to the forefront of the analysis because they are illustrative of the potential limitations and challenges of the current approach to spirituality in the workplace.

A movement to higher levels of abstraction is evident in much of the literature on spirituality in the workplace as scholars and practitioners seek to find an organizational definition and practice of spirituality which facilitates connection and meaning making (Cacioppe, 2000; Giacolone & Jurkiewicz, 2003; Mitroff, 2003; Mitroff & Denton, 1999; Vaill, 2000). For example, Mitroff offers us a "tentative working definition of spirituality" which claims that "Spirituality is the ultimate source and provider of meaning and purpose in our lives…Spirituality is the sacredness of everything, the

ordinariness of everyday life" (2003, p. 375). Mitroff argues that his definition transcends dualisms and fosters inclusion and connection, and I appreciate the intended consequences of this definition. Certainly, such a definition of spirituality may create space for the discussion of spiritual issues in organizations that have long been suspicious of communication about spirituality as enacted within particular religions. The experience at hospice does suggest that a pluralistic view of spirituality enables employees to meet the needs of patients from a wide array of spiritual perspectives. However, the results of this study suggest that the abstract definitions of spirituality have unintended consequences as well.

The first unintended consequence deals with issues of meaning making. If spirituality is fundamentally about making meaning out of chaos (Berger, 1967; Geertz, 1966; James, 1902), an ambiguous definition of spirituality may not serve to relieve us from the burden of chaos. Although some individuals embrace ambiguity in their spiritual journey (Fowler, 1981; Peck, 1993), other individuals have a high need for closure and low tolerance for ambiguity (Saroglou, 2002). For those with the second psychological makeup, the burden of meaninglessness might be especially problematic and increase their likelihood for burnout, particularly when employees work in health and human service organizations where they frequently deal with anomie inducing events involving human suffering and death (Boyle & Healy, 1999).

The second unintended consequence deals with issues of connection. The spiritual care philosophy at hospice rests upon the assumption that all individuals have their own sense of spirituality. As demonstrated in Chapter V, this individualistic

assumption about spirituality can foster a privatization of one's own spiritual experiences, a privatization that isolates one employee from another and limits their ability to communicate with one another on a deeper level. Instead of fostering connection, an ambiguous spirituality may foster disconnection and isolation. So, what does this mean for future studies of spirituality within organizations? The lessons from CCH suggest that it might be time to abandon, or at least question, the search for an appropriately vague definition of spirituality that will allow us to incorporate ideas of spirituality into the workplace while avoiding the potentially messy conflicts of religious pluralism.

Instead, organizational scholars interested in the role of spirituality in organizations need to start taking religion, including fundamentalist approaches to religion, seriously. In making this shift, it is also critically important to continue to take an ecological approach in our studies and consider the effect that legal, societal, and other institutional discourses about spirituality might have upon organizational functioning. In turn, we might also consider the lessons that these discourses, particularly legal discourses, offer us about balancing individual spiritual needs with the needs of organizations and communities. This is particularly important as religion continues to be a prominent force in shaping American institutions and the individuals that function within them (Armstrong, 2001).

The ecological approach in this study demonstrates that the tensions between individualistic spirituality and more fundamentalist religion at CCH reflect similar tensions in the surrounding communities, particularly in Oakville. Bellah, Madsen,

Sullivan, Swidler, and Tipton (1985) suggest that these tensions are prominent in American society at large as "spiritual individualism" and "fundamentalist religion" form the two poles that organize much of American religious life (p. 235). Although the spiritual individualism pole may have been the strongest at the end of the 20th century, fundamentalism is gaining in strength once again. Armstrong (2001) notes that the tragedy of September 11th, 2001 has become a rallying point around which fundamentalism is reemerging as a major force in America and around the world as individuals try to find a way to cope with the alienation and anxiety of modern culture.

Armstrong's (2001) and Bellah and colleagues' (1985) sociological analyses suggest that the battle between religion and secularism is far from over and while the attempt to create a secular organizational spirituality is a well intended one, it is important to also focus our attention on the wider variety of approaches individuals might use to talk about religion and spirituality at work. In discussing the tension between diverse individual spiritualities and unifying fundamentalist religion, Bellah and colleagues suggest, "The limitation for millions of Americans who remain stuck in this duality in one form or another is that they are deprived of a language genuinely able to mediate among self, society, the natural world, and ultimate reality" (p. 237). For all of us, it seems talking about our inner souls, our understandings of meaning and ultimate reality, remains difficult. It is precisely this difficulty that communication scholars need to take seriously as they consider the role of spirituality in organizational and health communication.

Certainly, taking these issues seriously is daunting, for there are considerable ethical challenges to consider when studying religion and spirituality. Particularly in organizational settings where power differentials abound, the risk that those espousing particular spiritualities might become targets of harassment is great and organizations need to be very cautious about the potential for exploitation of individual spiritualities. Rather than keep us away from the study of spirituality, these ethical dilemmas may be the most important reason to focus more closely upon these issues. I turn next to the results in Chapters IV and V that are instructive in suggesting areas for future study and practitioner training regarding communication about spirituality.

Spiritual Care Training and the Leading-Following Dialectic

In Chapter IV, the analysis of care provider stories suggested a wide variety of techniques through which individuals might manage discussions of spiritual issues. Theoretically, this analysis expands dialectical theory beyond its primary focus on internal psychological tensions (Baxter, 1988, 1990; Baxter & Montgomery, 1996) to a focus on the fundamentally communicative leading-following dialectic. The praxis patterns used by care providers in managing this dialectic also have pragmatic implications for scholars and practitioners. For example, future studies might examine these communication strategies more closely in practice to determine the manner in which different strategies influence the relationship between care providers and care recipients. These strategies might also be examined in other settings to explore how conversations about spirituality might best proceed within classroom settings or within conversations with family members or friends.

Organizations might also use this typology of strategies as a point for discussion in care provider training. Many practitioners and scholars in both social work and medicine have suggested that care providers should talk with care recipients about spiritual issues (Bullis, 1996; Canda & Furman, 1999; Ellor, Netting & Thibault, 1999), but few practitioners actually receive any training in how such conversations might be managed (Koenig, 2002). At CCH, employees received little to no training regarding spiritual care policies and several employees reported feeling an initial sense of paralysis when it came to spiritual conversations. These employees were often so frightened that they might violate the organizational rules for following the patient that they avoided spiritual issues altogether. Training which focuses more directly on the leading-following, expert-novice dialectics inherent in these discussions might better prepare these care providers for the ethical dilemmas faced in these conversations.

Spirituality, Ambiguity, and Burnout

The final results chapter also suggests that we need to take seriously the relationship between care providers' emotional and spiritual health and organizational spiritual discourse. In exploring these outcomes, we might once again turn our attention to employee tolerance for ambiguity and contradiction. Recent theoretical work suggests that employees who have a higher tolerance for ambiguity might be poised to function more effectively in contemporary society without experiencing the stress of emotional and cognitive dissonance. For example, Tracy and Tretheway (2005) suggest that employees who embrace a "crystallized" identity, a multifaceted identity which

recognizes that employees have multidimensional selves, might feel less discomfort adopting a wide range of roles inside and outside the workplace.

This theoretical work might account for the comfort that some CCH employees felt in keeping their personal spirituality private while performing a separate spiritual identity at work. For these employees, the work self and the private spiritual self were all smaller parts of the greater self and the conflict between these selves was viewed as a normal, everyday part of being human. For them, the organization's ambiguous spiritual discourse enabled the performance of multiple roles and they appreciated this flexibility. In contrast, other employees experienced ambiguity as constraining as it limited their ability to bring their true, integrated self into the workplace. For these employees, the notion of a crystallized self seemed antithetical to true spirituality. Future research might consider spiritual identity construction more directly to explore why some individuals were more comfortable embracing a crystallized identity, and how other individuals might cope most productively with spiritual and organizational identity tensions.

Unfortunately, even for employees who seemed more comfortable performing multiple roles, the potentially empowering notion of the "crystallized" identity was not allowed full expression of CCH because the organizational discourse silenced any real conversation about the difficulties and challenges of performing as Gracious Servants. Employees were allowed a wide range of subject positions as long as they did not challenge the prevailing hospice service ideology. As this very ideology was often a prominent source of stress for employees, the inability to talk about or challenge this

ideology often prevented employees from seeking social support and caused them to turn inward to manage their stress.

Previous research affirms that employees' ability to manage ambiguity and embrace alternative ways of managing workplace stress may be strongly influenced by organizational discourse. Meyerson (1994) found that institutional discourse which accepted ambiguity, stress, and burnout as normal parts of working in a human service context (the social work model) allowed employees to talk about their experiences with ambiguity and the stress they experienced working within a fluid care system. In institutions where ambiguity and stress were talked about as unnatural and pathological (the medical model), employees attempted to achieve a sense of control by minimizing or denying ambiguity and burnout.

Although the CCH managerial discourse embraced ambiguity as normal, it did not normalize stress and burnout. Rather, stress and burnout were viewed as individual problems indicative of an individual's inability to perform hospice work. My conversations with CCH employees suggest that stress and burnout are a normal part of the hospice experience and employees want to talk about these issues, but sometimes feel constrained in their expression because they don't want to burden other employees with their own "personal" problems. The idea that stress and burnout are "personal" problems is encouraged by the current managerial discourse and if CCH management is to take any role in limiting employees' experiences of burnout, employees must be encouraged to talk about both the individual and organizational precursors to stress and burnout. Opening up the dialogue about stress and burnout at the organizational level

might allow for the development of creative strategies through which employees and the organization can work together in managing stress and burnout. Finally, I turn to personal reflections about this dissertation process, both the influence my personal views have had upon this project and the influence this project has had upon me.

Personal Reflections

I began this chapter by talking about messiness and imperfect endings, and it seems I shall end it in a similar manner. As I write the final paragraphs of this dissertation, I find myself feeling uncomfortable with the messiness of spirituality and ethnographic work. Returning to my journal, I find that I have been concerned with these feelings throughout the project and that these concerns revolve around two central issues. First, I have continually been troubled by questions of ambiguity, both the level of ambiguity that I am comfortable with in my spiritual journey and the manner in which I use ambiguity to talk about spiritual issues. Second, I find myself troubled by the effect that this dissertation might have upon all of the CCH staff and my relationships with them. I turn first to my own struggles with ambiguity.

My personal struggles with spirituality came to the foreground early in this project and two early journal entries capture my dilemmas. On June 15, just two weeks into my data collection, I wrote the following in my journal: “My spiritual challenge in this project comes from listening to the stories. I’m more inclined toward an open, inclusive orientation, but then I’ll hear a story about ‘The Devil in Here’ or another story about a care provider’s strong Christian faith and I begin to wonder, what if their view is correct? Then we should be out evangelizing more.” As discussed in Chapter II, I was

raised in a fundamentalist, evangelical, Christian church and the spiritual answers offered to me in that setting suggested a realist ontology in which I learned that there was only one path to heaven and all those who didn't walk it were facing eternal damnation. In this setting, I believed that it was my job to share this truth with others. As a scholar, I look back upon this journal entry and think to myself, "Ah, proof of the power of the evangelical grand narrative that constrains individuals into a particular worldview. I must continue to work toward emancipation." However, as a young woman living in a chaotic society, this rational approach doesn't help very much when I try to make sense of the death and suffering that I see at hospice and come face to face with my earliest teachings.

At moments, I find myself longing for the clear answers offered by the earlier stops on my spiritual journey. On June 19, just a few days later, my journal entry reads, "This journey may be particularly challenging because the questions of spirituality are so central for me…I find myself longing to find the answer, the one answer that solves all the mysteries and struggles of my life. I think it is this view that I need to be most wary of – the seeking for an answer as opposed to the exploration of the questions leads me nearer to an attitude of judgment. At times, I want to find the ONE right path and yet, I want more to find peace and joy in the moment – to walk the right path for me." Because of my own personal conflicts and confusion, I found myself often falling back upon the ambiguous communication patterns used at hospice. With employees who were more certain about their spiritual path, I talked about my own faith in ambiguities lest they learn of my doubts and judge me or not trust me enough to answer my questions.

Challenges came from the other direction as well. In talking with one employee whose spiritual strength came from humanism, I found myself wondering how anyone could survive the day to day challenges of working at hospice without some sort of faith in God. As I sit in conversation with this employee, I find myself wondering where does one find moral and ethical grounding without some religious faith? Clearly, my own spiritual journey mirrors that of many hospice employees as we seek to find answers that will give us both individual strength and enable us to live comfortably in community. Of course, it could also be that my own spiritual journey guides me to see these issues in the stories of hospice employees.

I offer these reflections in closing this dissertation because they demonstrate the difficulties, the messiness of studying communication about spirituality. Spirituality deals with our inner selves and is intensely personal. To protect ourselves, we sometimes use ambiguous communication. At other times, the use of ambiguous communication is protective of others. In some ways, I believe that the use of ambiguity might be the best way to avoid the potential conflicts of life in a pluralistic world. Yet, I can't help but wonder if our abstract talk about individual spirituality prevents us from enjoying real connection and true community with one another. If we were really to talk about spirituality and talk about how we might best talk about spirituality, would we perhaps find more creative solutions and deeper connections with one another?

Perhaps the greatest test of this idea comes when I hand this final dissertation to the staff at hospice and allow them to read my story and my version of their stories. As they read this study that breaks through the ambiguity and makes public what employees

often keep private, I fear that some employees will feel judged by my comments and that others will judge me. I have deep admiration for all of the employees at hospice, so my heart breaks at the thought that they might be hurt by what I have written. However, I also have a great sense of hope that the employees who read this dissertation might feel validated in their struggles with spirituality and ambiguity, for these struggles are shared by all of us. I hope that this dissertation might facilitate conversations about the things in life that we each find meaningful, conversations about the ways in which we might best support one another in our spiritual journeys, conversations about how we might manage conflicts stemming from spiritual differences, and conversations about how we might best construct an organizational world in which personal spirituality in all of its manifestations is respected and honored.

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APPENDIX A

INTERVIEW GUIDE

Spirituality and Career History

I am interested in how your spiritual and/or religious beliefs impact your career. In order to find out how these are in harmony or conflict, let's start by having you tell me the story of how your career developed over time and how you came to be in your present position. Please start from where you feel you should. If at any time, you need some time to reflect, want me to turn off the tape recorder, or need a break, let me know.

- How did you come to hold these beliefs about how your career and your spirituality/religion should work together?
- What are the main differences, if any, between religion and spirituality for you?
- What education have you received for this position?
    - Was spirituality discussed during your education? Tell me how spirituality was discussed?

Spirituality at Hospice

- What is the role of spirituality in your workplace?
    - What is the role of religion in your workplace?
    - How does hospice feel about the incorporation of spirituality into your work?
- Who is in charge of providing spiritual care at hospice?
- Was spirituality discussed during your training or orientation at hospice? If so, how?
    - Do you feel you were adequately prepared to deal with spiritual issues in your work?
    - What improvements, if any, would you suggest?
- Is the manner in which you blend your spiritual and/or religious beliefs and practices with your work here different now from the way it was in the past?
    - What led to the changes?
    - Have there been any other turning points?
    - How do you see yourself changing in the future, if at all?
- Have you ever felt your spiritual and/or religious beliefs were in conflict with your work here at Hospice?
- Have you ever felt your spiritual and/or religious beliefs were helpful to you in your work here?

Spirituality in Interactions

- Tell me about an interaction with a client or patient about spiritual and/or religious issues at work. How did you feel during this interaction? Who initiated this interaction? Do you commonly have interactions of this type? Can you tell me any other stories?
- Tell me about an interaction with a co-worker or subordinate about spiritual/and or religious issues at work. How did you feel during this interaction? Who initiated this interaction? Do you commonly have interactions of this type? Can you tell me any other stories?
- Tell me about an interaction you have had with a supervisor about spiritual and/or religious issues at work. How did you feel during this interaction? Who initiated this interaction? Do you commonly have interactions of this type? Can you tell me any other stories?

Spirituality and Coping

- Working at hospice can often be very stressful. What gets you through hard times at work?
    - Has their ever been a time when your spiritual and/or religious beliefs helped you cope with the stress of your job?
    - What particular stressors seem to have the most impact upon you spiritually?
    - How do you maintain emotional and spiritual well-being in your work?
    - Do you ever perform spiritual practices, such as prayer or meditation, at work?
        - How do others in your workplace react to such practices?

Conclusions

- Is there anything else you think I should know about you, hospice, or the role of spirituality in hospice as I move forward with this study?
- Do you have any questions for me?

APPENDIX B

REVISED CODING SCHEME

I Manifestations of Spirituality
- A. Communion with patients
- B. Hospice Angels
- C. Celebration of Life
- D. Hospice Workers Prayer
- E. IDT and spirituality
- F. Prayer in Office
- G. Prayer Inservice
- H. Spiritual Assessments
- I. Replenishing Room
- J. Medicare Funding and Spirituality

II Patients and Spirituality
- A. Patient Story
- B. Patient Visions
- C. Prayer with patients
- D. Process of Spiritual Care
- E. Different Faiths Patient and Care Provider
- F. Communication Dilemmas with Spirituality

III Coworkers and Spirituality
- A. Coworker story
- B. Nurse Social Work Conflicts

IV Organization and Spirituality
- A. Hospice Culture
- B. Hospice Mission
- C. Hospice Praise
- D. Organizational Definition Spirituality
- E. Organizational Role Spirituality
- F. Organizational Rule Spirituality
- G. Financial Stressors
- H. Spirituality and Hospice Orientation

V Role of Spirituality in Job
- A. Role of CEO
- B. Role of Chaplain
- C. Role of Spirituality in Job

VI Community and Spirituality
- A. Oakville/Mayburg Comparisons
- B. Community Expectations

VII Personal Spirituality
- A. Benefits of spirituality
- B. Conflicts and Spirituality
- C. Professional Personal Tension
- D. Personal Definition Spirituality
- E. Personal Role of Spirituality
- F. Personal Spirituality and Death
- G. Religion vs. Spirituality
- H. Spiritual Guilt
- I. Spirituality and Professional Training

VIII Stress
- A. Compassion Fatigue
- B. Coping with Stress
- C. Source of Stress

IX Other
- A. Favorite Part of Job
- B. Hardest Part of Job
- C. Managing Ethical Issues
- D. Discussion of Jennifer's Spirituality

VITA

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