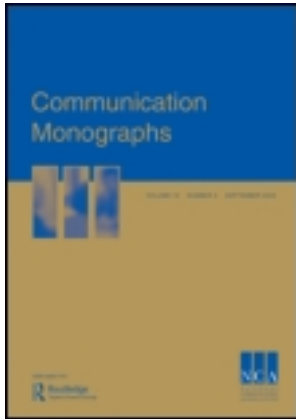


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Conceptualizing Compassion as Recognizing, Relating and (Re)acting: A Qualitative Study of Compassionate Communication at Hospice

Deborah Way & Sarah J. Tracy

Using qualitative data gathered among hospice employees, this study explores the communication of compassion at work, providing an in-depth understanding of one of the most quickly growing healthcare contexts and offering a new conceptualization of compassion. The analysis is framed with emotional labor, burnout, and compassion literature, and shows how communicating compassion emerged as a central theme. The heart of the paper provides a rich description of hospice workers as they engaged in the compassionate communication activities of recognizing, relating, and (re)acting. The study extends past research on compassion, highlighting its holistic nature and providing a model that demonstrates its core communicative action. In doing so, it opens the door for future research and suggests practical implications for practicing compassion at work.

Keywords: *Compassion; Emotion; Hospice; Organizational Communication; Qualitative Methods*

My favorite part of job? The human contact. I realized at an early age that I want the human contact. The empathy not the sympathy. It is the caring, you know, that

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you've done a good job . . . You know some people say, oh you'll get your reward in heaven, but there are rewards right here on earth. It is not the praise you get, it is the ability to make a patient's death comfortable with dignity. (Nurse Irene)

It only made sense to dedicate my life to hospice work. I don't think there is anywhere else that you can laugh and cry with people all in the same breath. (Nurse Carrie)

In this qualitative field study, we provide an in-depth account of the verbal and nonverbal communication associated with compassion at hospice—the ideological movement and resulting healthcare system designed to peacefully comfort and care for terminally ill people and their families. We demonstrate how compassion is accomplished through communication behaviors like listening, attending to non-verbal cues, and providing verbal social support—skills that allow employees to beneficially influence organizational functioning and workplace outcomes. Our study responds to calls for increased research on meaningful work (Cheney, Zorn, Planalp, & Lair, 2008), provides a picture of one of the most quickly growing healthcare contexts, extends theoretical conceptualizations of compassion (Kanov et al., 2004; Miller, 2007), and offers practitioners a valuable tool for identifying opportunities for compassion in a range of workplace contexts.

Organizational study of compassion is quite rare. The preponderance of emotion research in organizational communication has examined burnout (e.g., Tracy, 2009), workplace bullying (e.g., Lutgen-Sandvik & Tracy, 2012) and emotional labor (e.g., Miller, Considine & Garner, 2007). Although this research provides important insights about organizations and employee well-being, it also suggests that emotion is problematic, difficult, and leads to negative personal and work-related outcomes such as stress and alienation. However, work can also be context and cause for joy, empathy, compassion, and other positively blushed emotions. As Frost (1999) noted, “There is a whole rich, vibrant, exciting world of understanding about organizational life that is waiting to be engaged, and one of the keys to this engagement is compassion” (p. 131). The current study of hospice, part of the ever-growing but largely isolated business of death and dying, demonstrates how the communication of compassion is “an essential, yet often overlooked aspect of life in organizations” (Kanov et al., 2004, p. 809).

Hospice and Palliative Care

Numerous studies report that people prefer to die at home, free of pain, surrounded by their loved ones (see Kastenbaum, 2004). Hospice attends to this desire, eschewing traditional forms of terminal care that rely on often futile measures to prolong life. Instead, hospice advocates less obtrusive end-of-life techniques, keeping the dying relatively free from pain (Levy, 1989). Referred to as *death with dignity*, hospice holistically supports both physical and psychosocial needs, treating dying patients and their families as the central unit of care. Hospices are staffed by physicians, nurses, home health aides, social workers, counselors, clergy, and community volunteers. This specially trained medical team develops a care plan tailored to

patients' needs for pain and symptom management. A family member or loved one serves as the primary caregiver and helps make health decisions. Although 96% of care takes place in the patient's or their family members' homes (NHPCO facts and figures, 2007), inpatient units serve patients whose symptoms can no longer be managed, or when their home care-givers need a break.

Given that 79 million Baby Boomers are now beginning to retire (Pew Research, 2008), healthcare—and specifically end of life care contexts—offers a ripe venue for studying emotion at work. Healthcare will generate more new jobs than any other industry in America until at least 2018 (Bureau of Labor Statistics, US Department of Labor, 2010). Unfortunately, research shows that employees who work in personal care, social services, and healthcare experience the highest rates of depression of all US workers (NSDUH report, 2007). These statistics suggest the global significance of studying healthcare employees' well-being.

With regard to hospice, most existing research emanates from social work, sociology, gerontology, nursing, and medicine, where topics have included stress in palliative care workers (Lyall, Vachon, & Rogers, 1980), burnout in hospice nursing (Payne, 2001), and the risk of compassion fatigue in hospice nursing (Abendroth & Flannery, 2006). One of the most interesting themes emerging from this research is that hospice workers differ from other healthcare employees in reporting low depression and high job satisfaction (Qaseem, Shea, Connor, & Casarett, 2007).

Across the breadth of communication health-related research, attention to hospice is rather sparse. Noteworthy exceptions include valuable ethnographic accounts of communication amongst hospice interdisciplinary teams (Wittenberg-Lyles, 2005; Wittenberg-Lyles & Oliver, 2007) and an analysis of hospice volunteers' narratives functioning as sense-making about death and dying (Wittenberg-Lyles, 2006). Additionally, Considine (2007) has examined spiritual communication among hospice workers, volunteers, and their patients and the tensions that caregivers manage as they discuss spirituality at the end of life (Considine & Miller, 2010). The current study extends these understandings, providing additional insight regarding why hospice employees might have such high rates of satisfaction compared to other healthcare employees.

Emotional Labor, Compassion Fatigue, and Burnout

The first author, Debbie, first became acquainted with hospice as her mother died from lung cancer in 1998. Several years later, she pursued a research project to better understand how hospice nurses manage such emotional work. The emotion research in organizational communication and health (Tracy, 2008) suggested the salience of several theoretical areas for framing such a study, including burnout, compassion fatigue, and emotional labor.

Burnout—originally conceptualized as a consequence of caregiving stressors—is a three-dimensional concept characterized by (1) emotional exhaustion, (2) depersonalization or a negative shift in responses to others, particularly clients, and (3) a decreased sense of personal accomplishment (Maslach, 1982). Caregivers are

especially susceptible to burnout because of their frequent communicative interactions with distressed clients. Researchers distinguish between two types of empathy (Miller, Stiff & Ellis, 1988). *Emotional contagion* is the taking on and sharing the emotion of another person, while *empathic concern* is concern for another's well-being without the sharing of emotion. Emotional contagion impacts workers' perceived ability to respond appropriately. Burned out employees become detached, cynical, depersonalized, and callous (Tracy, 2009). Hospice and palliative care workers work closely and intensely with seriously ill individuals and their families at stressful and emotionally intense times in their lives. As such, it makes sense that such activities might not only cause burnout, but also lead to a more specific type of fatigue.

Compassion fatigue is a form of secondary traumatic stress associated with the "cost of caring" for people in emotional pain (Figley, 2002). The concept evolved from the study of employees who witness suffering, such as nurses (Abendroth & Flannery, 2006) and mental health employees (Becvar, 2003; Collins & Long, 2003). Hospice employees often enter the profession desiring to help others or "make a difference." In this capacity, workers connect and empathize with their clients, and past research cautions that when "our hearts go out to our clients through our sustained compassion, our hearts can *give* out from fatigue" (Radey & Figley, 2007, p. 207).

Related to compassion fatigue and burnout is emotional labor, which requires either inducing or suppressing displays of emotion in order to present an organizationally prescribed appearance (Hochschild, 1983). Emotional labor is associated with alienation and workplace dissatisfaction (Tracy, 2005), especially when workers feel emotive dissonance, or a clash between inner feelings and outer expression (Hochschild, 1983), and a resulting sense of inauthenticity (Ashforth & Tomiuk, 2000; Tracy, 2005). Of course, all work that is emotional is not necessarily emotional *labor* (Miller et al., 2007). That is, not all employee emotion is inauthentic or organizationally mandated, or feels "put on." Sometimes the work itself is emotional, and employees feel they are authentically expressing warranted emotion.

Debbie originally approached fieldwork well informed by the concepts of burnout, compassion fatigue, and emotional labor. She sought to better understand how hospice employees communicatively managed emotionally demanding work in an organizational context of illness, pain, and death. It was only after immersion in the hospice field that she recognized that most hospice employees contested the idea that their jobs were excessively (or negatively) laden with emotion. On the contrary, hospice nurses said they found their work enjoyable and fulfilling. Debbie also recognized a change in her own attitudes about death and dying. Whereas she had originally felt fear, anxiousness, and dread, she began to view death with increasing calmness, understanding, and acceptance. While she welcomed these pleasant feelings at a personal level, they stymied her at a scholarly level. The burnout, compassion fatigue, and emotional labor literatures suggested that, over time, care-workers often transitioned from empathy and investment to emotional exhaustion, depersonalization, and alienation. In contrast, Debbie witnessed and experienced something

qualitatively different, which is exemplified in the following conversation with social worker Leah:

Debbie: When I first started volunteering . . . there were so many times I would find myself on the verge of tears . . . Over time the same circumstances or types of incidences wouldn't bring me to tears. And my academic advisor would say, well, what you are describing is a symptom of burnout. And I would say, it's not burnout. I only volunteer four hours a week. I'm not burnt out. She said, well desensitization is a symptom of burnout. I would say, I know the feeling and I know it's not burnout. I'm not there enough to be burned out . . . It's not depersonalization! And I have a hard time getting that across to people who don't understand. What do you think? Have you had similar experiences? Do you know what I'm talking about?

Leah: Oh sure! I don't want to deny the value of having emotion because that's what connects us as human beings. But you know, you don't keep the rawness . . . I don't think it is depersonalization . . . I think of it as normalization. It is normal and healthy and appropriate to be involved in the fluidity of life. Life is fluid, why must we attach these negative labels to everything instead of trying to understand how the frame has changed?

Emergent data like these marked a transition in the study where we sought out literature that could usefully frame the fuller spectrum of salient emotions at hospice—not just detachment and rawness, but connection and warmth. We found that in the nascent compassion literature.

Organizational communication researchers have recently begun to take notice of the productive and positive aspects of emotion and communication at work (Lutgen-Sandvik, Riforgiate & Fletcher, 2011). Some of the most dramatic examples of organizational flourishing are found in difficult and challenging situations (Dutton, 2003). Compassion is similar to empathy and sympathy, involving “other-oriented” feelings (Batson, 1994). However, compassion goes “beyond an individual feeling of empathy and is expressed through action of some sort” (Frost, Dutton, Worline & Wilson, 2000, p. 27). Compassion requires “feeling and acting with deep empathy and sorrow for those who suffer” (Stamm, 2002, p. 107).

Scholars have attempted to systematically model the emotional activities of sympathy, empathy, and compassion, breaking them into component parts. Sociologist Clark (1997) sought to understand the social and cultural phenomenon of sympathy and engaged in a potpourri of research methods including the analysis of sympathetic characters depicted in fiction and nonfiction, an experiment that manipulated respondents' feelings of sympathy, and interviews regarding attitudes toward giving and getting sympathy. As a result, Clark delineated three important stages in the interactive sympathizing process: empathy (role-taking), sentiment (feeling), and display (of those feelings). From Clark's (1997) model of sympathy, Kanov et al. (2004) developed their theoretical model of compassion, identifying three interrelated processes: (1) *noticing* another's emotional state; (2) *feeling* the other's pain (through empathic concern), and (3) *responding* by working to alleviate another's suffering. Subsequently, communication scholar Miller (2007) took up Kanov and colleagues' model as her starting framework. Miller's interview data

suggested a slight extension, specifically that the second subprocess of compassion would be better described as *connecting with* individuals, as opposed to Kanov et al.'s (2004) *feeling for* them. Kanov et al. contend that people do not enter the realm of compassion until they actually *feel* for another's suffering through empathic concern. Miller found that, although her respondents felt empathy and concern for their clients, they most often described this process as a *connection* that involved not only feeling, but also cognition. Miller argued that this second component of compassion was not just about internal feeling (psychological and purely affective), but also about behavioral communicative process (experiential and relational). Miller thus frames compassion as squarely communicative and social, whereby the subprocesses of noticing, *connecting*, and responding to another's suffering are part of the organizational culture and are shared by organizational members.

Miller (2007, p. 238) suggests that future studies would benefit from observational research, noting that "One facet of traditional communication theory commented on consistently by the respondents in this research was the importance of nonverbal communication"—especially the integral roles of touch, active listening, and body orientations as ways of indicating compassion. We agree that conceptualizing compassion could benefit from field research that captures the *embodied* aspects of compassion—that which is material in touch, glances, and being. By *observing* and *experiencing* compassion in real-time action, this study strengthens and extends current compassion models.

A Qualitative Methodology for Understanding Compassion at Hospice

The stories that could be told from this study are many—ranging from Debbie's autoethnographic journey associated with her dying mother, to hospice clients' stories of death, to the structural paradoxes and challenges employees face as they attempt to practice holistic medicine in a bureaucratic healthcare structure. The analysis here focuses on in-depth qualitative research that specifically extends and enriches an organizational communication model of compassion. Through field work and long-term participant interaction, ethnography privileges the body as the site of knowing and provides tools for rigorously incorporating researcher emotion, intuition, and self-reflexivity (Ellis & Bochner, 2000).

Study Sites and Participants

Debbie collected data at Desert Hospice and Sun Canyon Hospice (facility and participant names are pseudonyms). Both are located in a large metropolitan area in two different Southwestern states of the United States, and both are owned by large for-profit hospice conglomerates. "For profit" hospices have grown twice as quickly in the United States as government-owned and nonprofit hospices in the last 10 years and now constitute the majority of Medicare certified hospice organizations (NHPCO facts and figures, 2010). The two contexts chosen, compared to three others considered, granted Debbie full research access, allowing her to openly

participate with patients and their families, volunteer, travel on field visits, interview a range of employees (including administrators, spiritual care providers, nurses, and aids), and generally become a regular member in the hospice's daily activities.

The data included contact with 96 participants—32 nurses, 23 aides, 14 social workers, 4 spiritual care providers, and 23 others (staff, maintenance workers, doctors, etc.). Of these, 67 people were observed for an extended period and/or formally interviewed and 29 were briefly observed or informally interviewed. About 75 percent of the employees were female, and about two-thirds Caucasian. On any given day in the field, Debbie also observed and/or interacted with 10 to 20 patients and their family and friends.

Desert Hospice is the second largest hospice in its metropolis. Inpatient stays typically average one week or less. Nurses and aides work 12-hour shifts—6:30 to 6:30. Inpatient units staff a full time social worker and a spiritual care provider who visits two days a week and additionally as requested.

Sun Canyon Hospice operates a different metropolis's largest inpatient unit. Although the majority of Sun Canyon's services are provided to clients at home, most field research took place at its inpatient facility. The facility has its own kitchen, laundry, chapel, minister, facilities manager, and janitor. Employees work eight-hour shifts, staffed by one front desk intake nurse, two nurses working directly with patients, and two nurse assistants.

Data Sources and Procedures

Data were gathered over six years (with focused collection Fall 2002 and Winters 2006–2007 and 2007–2008), logging a total of 192 research hours and yielding 508 single-spaced, typewritten pages of data. Data sources included participant observation fieldnotes (277 pages), informal ethnographic interviews (47 pages), and transcribed structured interviews (184 pages). The research passed human subjects review and participants gave informed consent.

Field activities included observing employee training sessions, shadowing employees in their work at inpatient units and as they made rounds to clients' homes, and Debbie's autoethnographic reflections on volunteer training and activities. This variety of participation levels provides multifaceted insight into the scene. Some fieldnotes were taken from the vantage of full observer, sitting at the nurse's station jotting notes, while others were from a participant perspective, recording the anxieties, accomplishments, frustrations and joys at being a full-fledged hospice volunteer. Volunteer activities included direct patient care, such as feeding and grooming; housekeeping, such as changing beds; and family and/or patient comfort care, such as healing touch massage. Time was also spent sitting and talking with patients, family members, and employees.

Headnotes and scratchnotes (Lindlof & Taylor, 2002) were taken in the field, and typed into full fieldnotes within 48 hours. Fieldnotes focused on interactions amongst employees and patients as well as subjective reflections and personal

experiences. These provided insight regarding the holistic nature of hospice and were integral for discerning the limits and opportunities of various theoretical frameworks.

Interviews

Interviews with 29 nurses, nurse assistants, social workers, and spiritual care providers ranged from 30 minutes to two hours, with a mean length of one hour. Seven of these 29 were informal interviews, resulting in 47 pages of single-spaced typed fieldnotes. These encouraged stories to unfold within the rhythm of work—over cups of coffee, commutes to clients' homes, or breakroom discussions. Twenty-two formal respondent interviews (Lindlof & Taylor, 2002) resulted in 184 pages of typed single-spaced transcripts. Participants elaborated on issues noted in fieldwork and shared both positive and negative workplace experiences. Queries included, "What energizes (or depletes) you at work?," "Can you tell me about a time when you felt especially appreciated (or unappreciated) by a patient (or client or coworker)?," and "Can you tell a story about a particular incident or patient that stands out in your mind?"

Methods of Analysis

We relied upon a two-level iterative analysis, alternately using etic-level categories based on existing research and theory and emic-level categories that emerged from the data and participants' voices (Miles & Huberman, 1994). Through reading and rereading the data using a version of Charmaz's (2005) constant comparative method we identified 83 first-level open codes (Lindlof & Taylor, 2002), such as "care-taking," "fragility," "sensemaking," "confronting one's own vulnerability," and "maintaining boundaries." After engaging in open coding, we began to identify relationships and second-level analytic themes in the codes, a process facilitated by the use of NVivo qualitative data-analysis software. Open codes were classified into categories, analytic memos explored the categories, and new pieces of data were added to categories until they became theoretically saturated (Charmaz, 2005).

This second wave of coding resulted in the creation of 10 second-order categories, two which were especially worthwhile for extending the concept of compassion—*suffering* and *emotion*. Connected to the suffering category were first-level codes such as responses to patients' suffering, outward expressions of suffering, grief, attending to patients' suffering, and making sense of suffering. The emotion category included first level codes such as emotionally intense situations, connecting with patients, and emotional impact of death. These categories prompted the authors to revisit and examine the subprocesses of noticing, feeling/connecting and responding as described in the current compassion literature. Additional analysis suggested the salience of hospice employees' compassion at work—not only with their clients, but also with their family members, each other, and themselves.

Compassionate Communication in Hospice

Given our focus on hospice workers' compassionate communicative experiences, interactions, and behaviors, the following vignette provides an exemplar of compassion in action.

Elizabeth is 92 and an itty-bitty little woman with a full head of wiry gray hair and dementia. Elizabeth likes to snuggle up in the recliner under her own fleece blanket, and that big 'ole chair nearly swallows her up. She is always cold, probably because she is so tiny. Elizabeth is nursing assistant Charlene's favorite patient. Every chance she gets, Charlene goes in, gives Elizabeth a kiss on the cheek and fusses with her blanket. Although I thought Elizabeth was bed-ridden—or should I say chair-ridden—when I arrive today I find Charlene holding Elizabeth's hands and slowly, methodically guiding her from the bathroom back to her recliner.

Charlene patiently encourages her, "Now the other foot. You're doing great Elizabeth! The doctor would be so proud of you." With each small step Elizabeth lets out an equally small sigh. Step. Sigh. Step. Sigh. Step. I smile, wondering if she is thinking, "Why do I have to walk? I'm 92. Carry me!" Elizabeth finally makes it back to the chair and emits a little moan as she melts into the chair.

Charlene grabs the hairbrush out of the bedside table and starts brushing Elizabeth's hair. With more concern and attention than any beautician I've ever seen, she produces a scrunchie and secures Elizabeth's hair into a tidy bun. Elizabeth, who usually acts as if she is half asleep, suddenly seems very awake. She turns her face towards Charlene, tilts her head, and asks with furrowed brow, "What do I call you?"

Charlene laughs, throws her arms around Elizabeth and says, "Charlene. You call me Charlene. I love you soooo much." Charlene tucks Elizabeth into her blanket and gives her one last peck on the cheek before she bounds from the room.

In this single vignette, we see a vivid picture of compassion at work. Charlene provides compassionate assistance, reassurance, and care through multiple verbal and nonverbal means—noticing that Elizabeth needs help, emotionally connecting with her, and actively providing physical support.

Our discussion of findings, below, is organized into three sections inspired by past literature that conceptualizes compassion as a three-part experience composed of (1) *noticing* another's suffering (through paying attention and listening to emotional cues and context); (2) *feeling and connecting* (through perspective taking and empathy); and (3) *responding* to the suffering (through active attempts to alleviate the pain) (Kanov et al., 2004; Miller, 2007). Each section shares data from the field, and explains how our findings reflect yet extend the conceptualization of compassion as a process of "recognizing," "relating," and "(re)acting."

From Noticing to Recognizing

Kanov et al. (2004) state that the first part of compassion, noticing, "requires an openness and receptivity to what is going on in those around us, paying attention to others' emotions, and reading subtle cues in our daily interactions with them" (p. 812). Furthermore, they assert that noticing can be the result of consciously

recognizing another's suffering or an unconscious emotional reaction to that person's suffering. Miller's (2007) research, on the other hand, found that noticing entailed "not only the need for compassion, but also noticing details about another's life so that the compassionate response can be made in the most appropriate manner" (p. 235). Our participants similarly articulated this subprocess of compassion—something we argue is not just a process of noticing, but one we call *recognizing*.

Noticing, by definition and theorization, suggests awareness, attention, and observation. Recognizing goes further and implies noting the *meanings* of communication behaviors as well as the meanings of what is *not* being communicated. Recognizing implies that we understand the value in others' communicative cues, timing, and context, as well as the cracks and schisms between various messages. Engaging in this multifaceted type of recognizing was an important aspect of compassion for hospice workers. For example, Nurse Irene explained how she must go beyond the surface of noticing what patients say to recognizing their meaning:

Patients and their families will tell you what they fear, what they worry about, what they believe in, what they value. But you must listen openly and ask questions. Sometimes people say they are in pain, but what they really want is someone to sit and talk with them. I say, "Tell me about your pain." Sometimes it [professing pain] is an attention getting device and that means that I have to find out what is really going on with them.

In this example, Irene demonstrates how communication with clients is far from straightforward. The process of recognizing entails making extra effort to identify and understand the root cause of patients' distress. In interactions with her clients, Irene actively seeks understanding through strategic questioning. Likewise, social worker Beth said, "I have to do more than listen to words—I have to listen to the meaning of words, and then ask questions to clarify." In short, the subprocess of recognizing is more than just being "open and receptive" to the needs of clients; it is actively searching out someone's need through interaction, paying attention to multiple communicative cues, and trying to make sense of the fissures between various verbal and nonverbal messages.

Recognizing is especially necessary due to the holistic nature of hospice care. Patients are part of a medical system that includes a clinical diagnosis, a community of caregivers, and an array of unique psychological and spiritual issues. As social worker Leah stated, "You don't know if the patient just lost two sisters, or a son died very young, or, did the wife just find out she's sick? You have to stop and think about this stuff." Hospice clients' needs almost never look the same, so the process of recognizing is extremely important. As nurse Mary remarked, "You have to be able to see a *person*, not just a list of diseases or complaints."

This type of holistic recognizing was evident in many observations. For example, shortly after one brief 10-minute conversation amongst the unit manager Daniel, Debbie, and Gary, a newly admitted patient who loved fly-fishing, Debbie noticed Daniel standing in the hallway quietly shaking his head. She asked what was bothering him, and he replied, "Gary. He's really scared." Later that day, Debbie wrote in her fieldnotes:

I don't know where Daniel got that Gary was scared. I was there. He never said anything about being scared. In fact, to me he looked and talked as cool as a cucumber. Like he thought he'd be out fly-fishing next week. And Daniel didn't know the guy; he just met him when he was admitted. Daniel, though, seemed to intuitively recognize from that short conversation that Gary was scared.

Daniel's intuition, reinforced by years of experience, enabled him to identify and recognize Gary's fear. Over the course of the research, Daniel repeatedly asked Debbie to sit with a particular nonresponsive patient when no family members were present, because, as Daniel would say, "(s)he's sad and doesn't want to be alone," an assessment dependent upon his ability to recognize a need that patients did not explicitly communicate. Likewise, spiritual care provider David explained how he approaches angst-filled clients:

I can always tell when they're not sharing the whole story, or there's some pieces missing. What I'll do is I'll just ask myself, "What am I not hearing here? What am I missing?" Or, I mean, "Is there something you need to tell me, or you don't need to tell me. Is there something you need to tell God or someone in your family? Or do you want to talk to somebody else?" You know, I know that when people's eyes water up a little bit, there is something there.

In order to recognize patients' needs, David employs a communication strategy that includes interrogating both what patients say and what they do not say. Given the possibility that hospice patients may be nonresponsive, and hence may not emit any kind of outward signs of distress, a worker's ability to identify and understand clients intuitively is viewed as a special gift and valuable skill.

Workers described in great detail the process of intuitive recognizing, whether their patients were responsive or not. As nurse Janet stated, "I've always been hyper-tuned to those who suffer. I just know. . . I can sense it, even in absence of all things physical and tangible." Workers alluded to a crucial "sixth sense" as a means to recognize. Certified Nursing Assistant (CNA) Susan talked about singing bedside hymns for a nonresponsive woman near death:

I've been walking past this room all day, and every time I would look in and she just looked so sad and so lonely, you know. But I just kept on working and every time, every time I felt that she was pulling me, calling me in. Then it hit me. . . she doesn't want to die alone. I just knew that was why I was being pulled in.

Susan ascribed her actions to an intuitive recognition of her patient's "communication."

A number of scholars have studied intuition in healthcare in general (King & Appleton, 1997) and argued that hospice/palliative care practitioners, in particular, are more intuitive due to the holistic and personal nature of work (Dunniece & Slevin, 2002). Many of our participants discussed the value of intuition and indicated that it was a much-prized communication skill. Attention to the discrete details of each patient's situation is fundamental to the communicative compassion subprocess of recognizing.

From Feeling/Connecting to Relating

Kanov et al. (2004) label the second subprocess of compassion as feeling: “People feel compassion for someone else . . . Moreover, the feeling of compassion implies that the object of one’s compassion is experiencing some sort of pain or suffering . . . Feelings of compassion thus connect one person to another’s hurt, anguish, or worry” (p. 813). We agree that emotional connection is key to compassion. However, their label of this process as “feeling” is confusing and sets up a tautology—essentially that “feeling compassion is one component of compassion.” Miller’s model avoids using “feeling compassion” to define compassion and rather labels this second component as *connecting*. Miller’s “connection” emphasizes the experiential, relational, and communicative dimension, reflected in our data as well.

However, our data also suggest that it is not necessary to choose between either affective “feeling” or relational “connecting.” That is, we must not entirely dismiss internal affect (Kanov’s term “feeling”) and replace it with Miller’s “connecting.” With regard to hospice workers, both articulations bear fruit. Some respondents described empathic concern for their clients (e.g., “compassion means caring about what your clients are feeling and are going through, and then wanting to help them however you can” [Mary]), while others focused on connection with them (e.g., compassion means that “I shift away from myself so that I can accompany them on their journey” [Irene]).

Still other respondents described feeling for their clients without indicating a connection to them. For example, CNA Faith stated, “Sometimes people are just so mean and cranky that I don’t even like them or want to be around them. But then I stop and think, I’d be mean and cranky too if I were dying. It helps put everything in perspective.” In this situation, she shows empathy, even though she preferred not to be connected (“around them”). Faith went on to say about unresponsive patients: “Sometimes you just have to give it your best shot. These people, I never met them before, I never talked to them before, I don’t know them. I just stop and ask myself, what is it that I’d want?” Clearly, it is difficult to connect with someone who is unresponsive; however, feelings of empathy remain. Unmistakably, with regard to caregiving in general, and hospice in particular (in which workers often can only ‘imagine’ their impact on unresponsive patients), workers’ knowledge and skills are not solely clinical but are also situated in a web of social, cultural, and embodied experience (Skott & Eriksson, 2005).

So, what concept might better capture the second component of compassion? We offer “relating” as a concept that encompasses possibilities for both affective feeling and cognitive connecting, while not privileging one over the other or requiring both. “Relating” suggests identifying with, feeling for, and connecting with another in a consubstantial way. The consubstantial relationship is a shared sense of self (Burke, 1969)—a tight connection that facilitates communication and understanding. Relating is similar to the concept of identification—“more than simply engaging in cooperative activity. It is a feeling of mutuality that enables individuals to share the emotions, values, and decisions that allow them to act together” (Gossett,

2002, p. 386). As such, “relating” embraces cooperative mutuality and communicative interaction.

Relating took several forms at hospice. A number of employees said they felt “most alive” when they could “look in their [patients’] eyes and know that I made a difference” and/or “feel like I am valued.” Feeling as though they made a difference was fundamental. Indeed, Debbie felt similarly after volunteering with a particularly challenging patient who was fidgety, prone to accidents, and with whom she had a language barrier. This patient’s son—the woman’s primary caretaker—called Debbie aside and said, “Sometimes, I feel so alone. I can’t tell you how comforting it is to know that there are people like you and this place here for me and my mother.” That one statement from the woman’s son enabled Debbie to understand, experience, and relate to the woman at the level of feeling, because she knew she was making a difference in the lives of these two people.

Yet “relating” was more than just feeling. Workers would as frequently talk about experientially connecting with their clients. Nurse Carrie said:

So when I come to work, I always stop at the front door and say a little prayer. I pray and ask God to please not let me be so busy that my heart does not hear my patients. I need to be able to be sensitive to their needs and completely open and available to help meet those needs.

Carrie’s prayer is not only about recognizing her clients’ needs but sensitively relating with them. She feels that a heart-felt connection can help her be the best caregiver, and regardless of the extent to which she accomplishes this, Carrie purposefully thinks about relating as she begins her job each day. Likewise, social worker James explained compassion as, “the ability to let yourself hear and see someone fully so that when you give, you give fully.” These comments indicate how relating is an active communicative process that includes listening, feeling, identifying and making connections with others.

Similarly, Nurse Hannah provided an example of the importance of relating to a patient described by the intake nurse as ill-behaved:

Even though I’d been warned she was rude and angry, she wasn’t. During our first meeting, I just stopped and asked myself, “What’s going on with her?” Then I figured it out. She’s from New York and, having an aunt from New York, I was able to see that she was making jokes. When she realized I got it, it opened up the doors so she could talk about her fears and ask the questions she had. And we ended up really connecting and having a wonderful relationship and I still keep in touch with her son to this day!

Through identification and perspective taking, Hannah related with her patient and established common ground—something that benefitted both Hannah and her patient as they created a rewarding long-term relationship.

The importance of relationship for hospice employees extends to the way clients remind them of someone else they care about outside of work. Such patients can ignite a wide range of feelings depending on the employees’ relationship with the patient’s look-alike (or “seem”-alike). For example, if the patient is someone of

similar age, mannerisms, and/or appearance to a worker's loved one, the ensuing caregiving experience can be one of love, joy, trepidation or dread, depending on a litany of factors. Nurse Charlene offered a chilling story of working with a dying six-year-old girl. She was hesitant to take the case because her own daughter had died a number of years previously at the same age. Charlene recalled:

The day I met her, she appeared mesmerized by something around me. When I asked her what she was looking at, she told me there was a very shiny, bright light around my head and that it hurt her eyes. I thought maybe she was just photosensitive, so I went and got my sunglasses for her to wear, and she happily put them on. But she kept staring away at me. Then a few hours before she died, she was talking to another little girl . . . who was unseen by either her parents or me! I asked her who her friend was, what she looked like. She described my six-year-old daughter to a tee, including a birthmark she had been born with. I can't really describe it, but it was like I was overcome with this rush of warmth I hadn't felt in years.

Charlene made sense of taking on the case by reflecting that perhaps it was because her own daughter had empathically pulled her in to relate and care for the dying girl in her final hours. Charlene's story shows how the ability to identify with the "other"—patient, family member, or situation—can facilitate relating.

From Responding to (Re)Acting

Kanov et al. (2004) identify the third and final compassion subprocess as responding, described as "any action or display that occurs in response to another's pain, with the aim of alleviating that pain or helping the sufferer to live through it" (p. 814). The majority of their work presents noticing, feeling, and responding as linear, with responding coming as a result and indication of feeling (p. 814). However, at one point they acknowledge that responding can come before feeling (p. 814) and explain that responses, by themselves, are only compassionate when accompanied by noticing *and* feeling.

Our data suggest that the three processes of noticing (our "recognizing"), feeling/connecting (our "relating"), and "responding" are not mutually exclusive and that action/response can actually *precede* empathic feelings. For example, CNA Susan discussed changing a nonresponsive patient's gown, and because it was a slow day, she decided to massage his feet afterwards just to "kill some time." She explained:

So, I'm like just standing there massaging his feet, and I don't know what I was thinking about, but all of a sudden I felt his legs go limp, like completely relax. His breathing slowed down and got much quieter. I mean, I could see him just really relaxing while I was doing it. It made me feel like I was really making a difference for someone, no matter how small the gesture. I knew that I was really important at that moment. It made me feel really good.

As this example shows, the action (massaging his feet) came first and only then did Susan recognize and feel a connection with the patient. Furthermore, Susan chose to act, not to necessarily alleviate another's suffering, but to "kill time" during an

otherwise slow day. Yet, the action led to bonding and good feelings about a patient. In short, data like these suggest that actions, even if they come before or without empathic feelings, are key to compassion.

Compassionate actions were plentiful in our data. Workers talked about the importance of mindfully communicating with patients as a way to signify empathy and presence. CNA Katie explained that compassion means, “I am present in mind and behavior. THEY may or may not be talking—or even aware—but I am still talking, because that is how I make my presence known. If they are hurting, I’m responding verbally.” Social worker Sarah said she has been known to visit a nonresponsive patient’s room, sit with them, and:

Read. Anything and everything. I mean, when I’m too tired to come up with conversation or things to say, I’ve just sat there and read the lotion bottle ingredients to them. I’m hoping that they can feel that I am there with them and that I care.

Sarah described one particularly important aspect of her job as an inpatient social worker, saying, “Your role is to help the client make sense and understand that this is just a short-term, temporary place. So my first and primary role is to teach and advise them on all of that.” In this case, Sarah sees her compassionate response as multilayered and ongoing. She engages in assessing, teaching, advising, and facilitating the needs of her clients. Compassionate communication also extends to talking to others on the patients’ behalf. Social worker John stated, “I can help my patients by speaking up. If I disagree with the doctors or with the family members, I don’t hesitate to speak my mind. Of course, always on behalf of my patients.”

Participant observation data were especially worthwhile for highlighting a type of compassionate action that has been overlooked in past studies, and that was: *giving others the gift of quiet, time, and space*. This type of action would be less visible in Miller’s (2007) model which describes the subprocess of responding as “actually behaving or communicating in ways that could be seen as compassionate” (p. 233)—behavior that can be “seen,” presumably by the receiver or outsiders. A receiver-based approach is also quite common in the social-support literature (Albrecht & Adelman, 1984); that is, communication is considered supportive when the person receiving the support “*feels supported*” (Beehr, 1976, p. 36). However, our data suggest that compassionate action is often subtle—moving beyond what can be “seen” or identified by receivers or outsiders. Namely, compassionate action may come in the form of strategic *inaction*.

Nurse Hannah explained times when, “I know there just isn’t anything I can do. So I respect that and don’t do anything. I just give them their space.” Indeed, sometimes the best course of action was to let patients rest comfortably. As social worker John said, “My client needs to be left alone right now, so I will check back later.” At one of the inpatient units where Debbie volunteered, the workers placed a small silk butterfly outside the door of the room where an eminent patient (a patient expected to die within a day) rested. The butterfly placement marked the point after which workers provided the patient, family and friends with the gift of quiet, time, and

space. Caregivers did not chose “time and space” because they did not know what to do, nor was it akin to “doing nothing” or withholding care. In contrast, such actions were skilled and heartfelt gifts of compassion developed through training, experience, and intuition.

Given the importance of strategically giving quiet, time, and space, coupled with the data that suggest compassionate action often comes before and together with recognizing and relating (rather than simply as a response to another’s suffering), we offer the term *(re)acting* to capture this third subprocess of compassion. The parentheses around “re” indicate that compassionate action need not only be in response to or arise after the recognition of someone else in pain, but can also be proactive. In other words, this process can be “acting” as well as “reacting.” With this understanding, we define *(re)acting* as engaging in behaviors or communicating in ways that are seen, or could be seen, as compassionate by the provider, the recipient, and/or another individual.

A New Conceptualization and Model of Compassion

This qualitative analysis of communication at hospice provides a rich description of compassionate communication at work, offering implications for theory and practice. The study’s primary theoretical contribution is reconceptualizing compassion to *recognizing*, *relating*, and *(re)acting* (Table 1). We believe this conceptualization not only captures the subprocesses of compassion, but also highlights the integral role of communication. In naming the three compassion components with terms that all begin with the letter “R,” the conceptualization is also parsimonious and memorable.

Table 1 Reconceptualizing Compassion as Recognizing, Relating, and (Re)Acting

Kanov et al. (2004)	Miller (2007)	Way & Tracy
Noticing Paying attention to others’ emotions, and reading subtle cues	Noticing Noticing not only the need for compassion, but noticing details about another’s life so that the response can be the most appropriate	Recognizing Understanding and applying meaning to others’ verbal and nonverbal communicative cues, the timing and context of these cues as well as, cracks between or absences of messages
Feeling Feeling compassion for another’s suffering (affective)	Connecting Connecting with others (relational)	Relating Identifying with, feeling for, and communicatively connecting with another to enable sharing of emotions, values, and decisions
Responding Any action or display that occurs in response to another’s pain—must be accompanied by noticing and feeling	Responding Actually behaving or communicating in ways that could be seen as compassionate	(Re)acting Engaging in behaviors or communicating in ways that are seen, or could be seen, as compassionate by the provider, the recipient and/ or another individual

In addition to providing this conceptualization, our research suggests that (re)acting is the *core* component of compassion, differentiating compassion from the feeling states of empathy and sympathy. Compassionate action is in *response* to suffering, but also that communicative and behavioral action can be *proactive*, prompting employees to recognize and relate in new ways. Weick's (2001) model of organizational sensemaking supports the notion that action often precedes feeling and thinking. Particularly in situations consisting of ambiguity and uncertainty, people understand and make sense of their situation retrospectively, an idea that Weick (2001) encapsulates in the phrase, "How can I know what I think until I see what I say" (p. 189). In the case of compassion, we would suggest, "Caregivers *recognize* and empathetically *relate* through seeing how they (*re*)act." In short, (re)acting is at the heart of compassion, while recognizing and relating are the icing on the cake—that which gives compassion its richness and sweetness. Our study provides the basis for creating a visual model, pictured in Figure 1, which highlights the holistic and soulful nature of compassion.

This model is designed to aesthetically represent the processes of compassionate communication, tapping into its visceral nature. First and foremost, the model highlights the significance of the heart in compassionate communication.

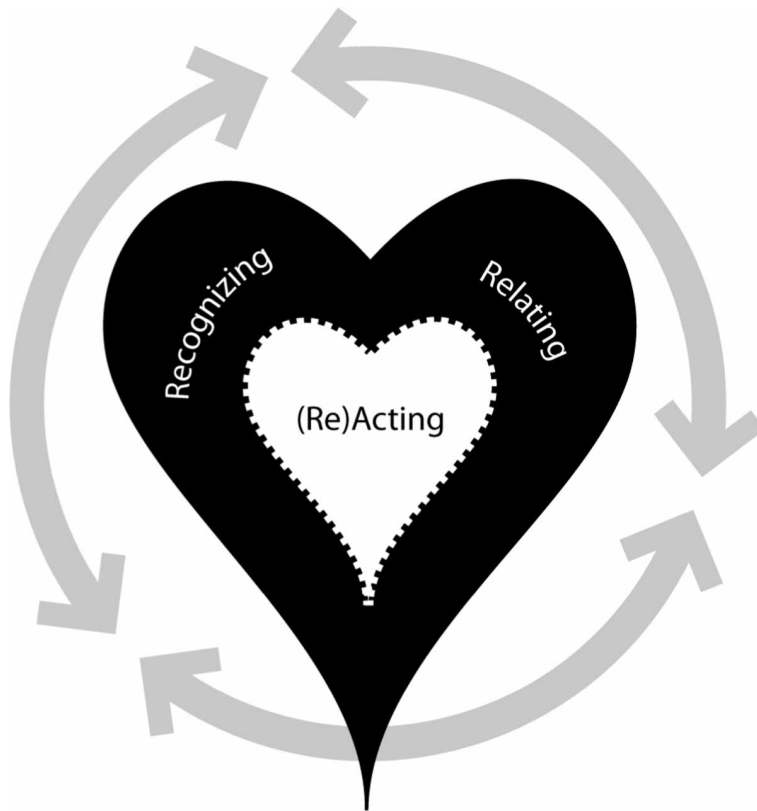


Figure 1 The compassionate heart.

Metaphorically, the heart is the center of emotion (Tracy, Lutgen-Sandvik & Alberts, 2006). From Hochschild's (1983) groundbreaking book on emotional labor, *The Managed Heart*, to everyday vernacular references (when we are sad, our "heart breaks," when our feelings are genuine, they are "heartfelt"), the heart is central in emotional imagery, and especially to the process of compassion. Social worker Leah discussed the emotional component of hospice work by stating:

You know, it's kind of like the heart gets stronger. I'm using the heart as a metaphor to get at the idea of the interior level of understanding. You allow the heart to open, you allow the heart to evolve and it's like an emotional muscle and it doesn't have to be collapsing into tears every time there's a poignant moment.

This quotation suggests that the heart is not just vulnerable—not just something that is potentially broken or stomped upon. Rather, just like any muscle, the heart gets stronger—more compassionate—with training and practice. The centrality of the heart in compassionate communication was evident in numerous caregiver stories—the word appeared 39 times in our field data. Participants said, "Patients get wrapped in your heart" (Leah), "The heart is an emotional muscle and hospice is all about the heart" (Sarah), "I communicate from my heart to their soul" (David), "She wears her heart on her sleeve" (Faith), and "Compassion is in your heart, not your head" (Dianne). Given the significance of these data, the heart provides the foundation for our model.

The *Compassionate Heart* depicts (re)action at the core, with recognizing and relating filling and completing the heart. As evidenced in our data, compassionate communication does not necessitate the presence of all three components. In fact, in many situations workers felt that when they were (re)acting, they were engaging in compassion—even when recognizing and/or relating were not immediately apparent, or if they emerged at a later time. The dashed line that surrounds (re)acting in our model shows the porous nature and overlap amongst these concepts. Encircling the compassionate heart are three bi-directional arrows, representing not only the three subprocesses, but also that these communicative activities can double-back, rather than necessarily progress in a linear fashion. And finally, our compassionate heart model features a point, or tail, which extends beyond the encircling arrows. This indicates that compassion is not an internal intrapersonal process—compassionate communication extends outside oneself to interaction with others. Our hope is that this model serves to vividly and precisely portray the compassionate process in a way unavailable through the "box and arrow" diagrams that currently populate many studies of emotion and burnout (Tracy, 2009).

Exploring the Parameters of the New Conceptualization

We were curious about the transferability of our renewed conceptualization of compassion, and found that it relates well to past research. For example, despite the fact that they posit a linear three-pronged model of compassion, Kanov et al. (2004) acknowledge that each subprocess is interrelated and may not be sequential, stating:

Although examining the three subprocesses independently of one other allows for a clearer understanding of each of them, in reality, these collective processes are highly interconnected. Different processes often take place simultaneously in a set of organizational members, and any one process may feed into another. (p. 821)

In another study, O'Donohoe and Turley (2006) addressed the emotional labor and compassion experienced by obituary journalists. Their findings also evidence that the subprocesses of compassion are not necessarily sequential and need not all be present in order for compassion to take place (see the narratives of Maeve, p. 1439 and Lisa, p. 1440 for examples).

Miller's (2007) research with human service workers also bolsters our model. Miller's data support the nonlinear nature of compassion, as illustrated by a respondent who discussed engaging in action in hopes of establishing a connection (p. 232). Additionally, Miller states:

Several interviewees saw the response as the most important part of compassion. For instance, a family practice physician (R#18) said, "Empathy is too disconnected. You're not human if you don't pour some of you into your patients." *In other words, it is not compassion if you do not respond.* (p. 233, italics added for emphasis)

Our model, which depicts (re)acting at the heart of compassion, vividly pictures Miller's conclusion—that it is not compassion without a response.

In short, our reconceptualization, terminology, and compassionate heart model, although emergent from data at hospice, appear to linguistically and visually capture compassion as described in a number of earlier studies. In addition to this theoretical contribution, our study also implicates practice.

Practical Implications

Given the increasing role of hospice in our aging population, our study suggests specific avenues for training healthcare workers. Because (re)acting is the overarching or core component of compassion, training employees in specific communicative actions is an excellent avenue for engendering and fostering compassion. The hospice caregivers in this study, by and large, believed that when seeking, recruiting, and hiring workers, the organization needed to find "compassionate people." This implies that compassion is a personality trait waiting to be found. In contrast, our findings demonstrate how compassion is a collection of behaviors that are constructed through communicative behavior.

Organizations can train individuals to be compassionate by privileging the (re)acting component of compassion, even when employees do not first feel empathy or connection. Although hospice workers are afforded more autonomy in their job than other healthcare specialties, they nonetheless follow a traditional organizational model in which some members powerfully control other members. If workers at all levels were encouraged to "think outside the box" with regard to (re)acting to their clients—for example, giving them foot massages, even when they were not directed

to—then positive feelings about themselves, their clients, and their jobs may ultimately result.

Multiple parties benefit from empowering workers to create compassion. Clearly, patients are a significant beneficiary, as they are likely to receive better treatment when healthcare employees recognize their pain, relate to them as whole human beings, and (re)act in ways that tend to specific needs. Furthermore, insomuch as relationship building and contributing to the greater good are primary characteristics of meaningful work (Cheney et al., 2008), workers themselves benefit from communicating compassion. Fostering positive social interactions through compassion also improves the collective organization (Gottschalk, Munz & Grawitch, 2006). An ethos of happiness can increase worker productivity, decrease stress, and enrich an organization's credibility and prestige (Gavin & Mason, 2004).

With regard to healthcare in particular, although the past literature suggests that many healthcare employees suffer from depression, burnout, and high turnover, hospice workers defy this norm (Qaseem et al., 2007). The centrality of compassion in their work may be an integral factor contributing to hospice workers' high levels of satisfaction. Our data show that employees' acts of compassion were accompanied by feelings of self-worth and appreciation for their work. These acts not only helped patients feel better, but also helped employees feel better in their jobs.

Limitations and Future Directions

Several limitations characterize this study that may be attended to through promising future research in compassion at work. First, space limited our ability to tease out the different variations of each subprocess of compassion in this essay. Future work could usefully explain the specific strategies that constitute recognizing, relating and (re)acting, and how they differ in terms of being intuitive, cognitive or behavioral in nature. Second, the conceptualization herein could be bolstered and/or problematized by investigating compassion from the perspective of the receivers—the audiences directly benefiting from the compassionate communication. Much like Miller (2007), our data focused on employees' viewpoints and workplace activities. Future studies could usefully consider compassion from the perspective of family members or those “overlooking” compassion. Understanding compassionate processes from the perspective of the receiver would also be fascinating—but as we found in early parts of this study, negotiating research access with people who are sick and dying can be quite difficult. Nonetheless, we encourage future researchers to consider contexts in which receivers/beneficiaries of compassionate communication might be more willing to share their understandings, perceptions, and experiences of compassion.

It would also be interesting to examine the limits and barriers to compassion. Although the majority of our data show that workers effectively communicate compassion, participants also noted instances when practicing compassion felt difficult (e.g., when clients were needy, crabby, or overdemanding). These instances

evoked strong feelings in participants, so exploring the feelings and sensemaking associated with compassion barriers is warranted.

Relatedly, future studies could fruitfully examine whether caregivers feel inauthentic when they perform compassion in situations where they feel it is undeserved. In our study, participants framed most patient interactions in a positive light. Despite the preponderance of positive patient stories, past emotion and dirty work research (Tracy & Scott, 2006) would suggest that hospice workers at least occasionally have negative or ambivalent feelings about their clients. Future research could further investigate why hospice workers do not cite their care as all that difficult. It may be that performing care aligns with their preferred sense of self, helps them feel powerful in the face of death, or that they do not view their patients as diseased or lower status.

In conclusion, this study reveals that the contours of compassion in organizational life are complex and dynamic. Further, our data highlight the importance of better understanding the conditions and factors that constitute the communication of compassion. Examining these conditions is an important complement to the study of emotional labor and burnout, helping provide insight on adaptive and energizing emotional processes and illustrating how work can be meaningful, engaging, and lead to human growth. We hope the model of communicating compassion herein may invigorate additional studies of care, generosity and compassion across workplace contexts, bringing “the organic, the moving and heartfelt, the emotional, and the relational elements of life into sharp relief” (Frost et al., 2005, p. 844).

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