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Secondary Emotional Labor: Supervisors Withholding Support and Guidance in Interdisciplinary Group Meetings in a Community Hospice Program

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Abstract

Emotional labor (EL) can be rewarding, but it can also lead to burnout. Research suggests that supervisor support may be essential to positive experiences with EL. Using qualitative data from a community hospice

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program, the authors compare interdisciplinary group meetings in which supervisors facilitated EL processing and skill building with those in which they imposed secondary EL, a dynamic that restricts these activities. The authors found that when leaders support EL talk, it increases the likelihood that workers will experience EL in positive ways, and thus improve their care of clients and the organizations for which they work.

Keywords
qualitative research, emotional labor, secondary emotional labor, supervisor support, hospice nursing

Researchers have been studying emotional labor (EL), the suppression of one's feelings to bring about a desired state of mind in a client, for decades (Lively, 2002; Polletta & Tufail, 2016). A classic example of EL is when a flight attendant continues to smile in acquiescence to a customer's demands despite their aggressive complaints about slow service and their use of vulgar language (Hochschild, 2003). Another is when a bill collector takes an adversarial stance toward a debtor, even if the collector harbors sympathy for the individual or people in their plight. Such anecdotes represent the way EL tends to be portrayed: service workers with few incentives beyond their paychecks controlling their feelings with disgruntled, rude, or otherwise challenging customers to conform with the presentational dictates set by managers (A. A. Grandey & Gabriel, 2015).

However, recent research, particularly on occupations with greater status and responsibility, has challenged these assumptions about EL (A. A. Grandey & Diamond, 2010). For example, nurses and other health-care professionals take care of sick patients at their most vulnerable, and the intimacy and personal nature of their EL can facilitate patient trust and therapeutic results (Theodosius, 2008). Indeed, engaging in EL may be one of the things attracting workers to such occupations, challenging assumptions that EL is a wholly unfortunate burden (Lopez, 2006). Moreover, the health-care literature argues that EL is undervalued and poorly supported, suggesting that its negative attributes may stem from organizational responses to EL rather than from the labor itself. For example, an early study of hospice nurses found that the amount of knowledge and skills needed for effective EL are equal to those needed for the physical aspects of patient care, and yet there were significantly fewer resources to support the former than the

latter (James, 1992). In addition, a recent study of call centers found that supervisor tactics, such as monitoring and reinforcement, increased worker commitment to emotional goals because they provided support for an otherwise undervalued aspect of labor (Holman, Chissick, & Totterdell, 2002). Together, these studies suggest that despite the intrinsic rewards of making a difference in people's lives, EL can be a difficult and stressful skill to engage and master, and organizational responses, even in the case of lesser status service work, can impact the experience of EL as much as individual characteristics or worker–client interactions. Stepping off these preliminary findings, this article asks, "how do supervisor responses to talk of EL shape the experience of human service workers, in this case hospice nurses, who are constantly managing their emotions as they care for their clients?"

Drawing on a 3-year ethnographic study of a community hospice program, this article shows that the instrumental and emotional challenges of EL are shaped by whether nurses have opportunities to process their experiences with supervisors and colleagues. We argue that when supervisors deny subordinates these opportunities, because of (perceived) resource constraints, they are imposing a second, more destructive, level of emotional suppression, which we label *secondary emotional labor* (SEL). This study is based on observations of interdisciplinary group (IDG) meetings that not only are designed for patient review but also feature EL talk. In the Background section, we review the theoretical underpinnings of EL, the tendency to frame EL as a negative experience, and recent work exploring its potential to be positive. In the results, we show how EL talk in IDG meetings allows health-care workers to access emotional and informational support from colleagues that provides emotional energy and skills for continued laboring. On the other hand, when supervisors enforce SEL, it interferes with the rewards workers get from engaging in EL, the development of skills for future work, and the achievement of broader organizational goals. We also share quantitative data about meeting dynamics that suggests that perceptions of time or other resource waste because of EL talk are questionable. Finally, the discussion considers the implications of SEL and how organizations can either reinforce this destructive dynamic or support the EL that is a central component of what makes organizations successful.

Background

EL is based on a relationship between an individual's emotional regulation—the management of facial expressions, and verbal and body

language during interactions—and the emotional demands of people work (Brotheridge & Grandey, 2002; A. A. Grandey, 2000; Hochschild, 2003; Wharton & Erickson, 1993). Subfields in psychology and management distinguish between two forms of emotional regulation, surface acting and deep acting. Surface acting is when an employee avoids sharing their actual emotions and instead expresses what they deem are the appropriate emotions for a given client interaction (Ozcelik, 2013). An example is when a physical therapist, despite feeling empathy for a handicapped child, is firm in overcoming resistance to treatment. Deep acting, on the other hand, is when an individual works to internally experience the emotions their environment or client is asking for (A. A. Grandey & Gabriel, 2015). An example is a social worker who is not feeling upset at the death of a patient, but in the presence of grief-stricken family members works to tap into past experiences of loss and ends up feeling sad and crying. Another component of EL is the formal and informal requirements set by organizations to manage the emotional expressions of employees when working with clients (Cropanzano, Rupp, & Byrne, 2003; A. A. Grandey, 2000). Although researchers differ in their opinions of EL, most agree that it involves emotional regulation in response to organizational norms for employee–client interactions (Bhave & Glomb 2009). Research on these dimensions has unearthed a number of findings about employees' EL experiences.

Studies in psychology and management show that EL is associated with diverse outcomes. Some researchers have found that an individual's well-being depends on which form of emotional regulation they most often employ. Specifically, studies suggest that deep acting is associated with well-being, while surface acting is associated with enhanced feelings of depersonalization, emotional exhaustion, and a reduced sense of accomplishment (Brotheridge & Grandey, 2002; A. A. Grandey & Gabriel, 2015; Ozcelik, 2013; Wallace, Edwards, Shull, & Finch, 2009). However, a number of studies argue that most individuals who are committed to the emotional requirements of an organization use both surface and deep acting with clients which can feed a deep sense of meaning and purpose that is associated with a variety of significant positive outcomes (Gosserand & Diefendorff, 2005). The literature suggests that this may be especially true for human service workers for whom surface acting and EL in general may be less insidious than for those employed in other occupations. Studies of 911 dispatchers reported that despite the "repeated and extreme suppression of emotion" (Shuler & Sypher, 2000, p. 84) and the need to display

"dispassion and authority" (Morris & Feldman, 1996, p. 991), many found their work gratifying, as echoed in sentiments such as "It's nice to feel that you did a good job and to know that you helped [someone]" (Shuler & Sypher, 2000, p. 75). In another study, nurses who worked in a Neonatal Intensive Care Unit (NICU) and cared for preterm infants and their families reported similar interpretations (Cricco-Lizza, 2014). One nurse described the stress of maintaining an "unflustered proficient bearing" with parents who are constantly present, even when their infant is struggling, and the rewards of EL when a parent came to visit her months after her baby had died to thank her for her "constant understanding" (Cricco-Lizza, 2014, pp. 617–618). This shows that recognition for managing one's countenance and suppressing one's anxiety to comfort a grieving family can be very meaningful. Moreover, other research suggests that those who work in professions where they have the power to relieve suffering and enhance well-being can, through emotional regulation, attain significant benefits for themselves (Bakker & Heuven, 2006). However, even among human service workers, the energy required for constant emotional regulation can undermine an employee's own health and well-being, particularly when they feel that their organization is unsupportive of their efforts (Chou, Hecker, & Martin, 2012).

Moving beyond a characterization of EL as entirely shaped by interactions between workers and clients, studies of service workers suggest that there are other factors, such as organizational support, that can buffer dissatisfaction stemming from emotional regulation (Duke, Goodman, Treadway, & Breland, 2009). A worker's perception of their value can be reinforced in a socially supportive context, provide a break from self-regulation, and help them regain emotional energy (Duke et al., 2009; McCance, Nye, Wang, Jones, & Chiu, 2013). In one experiment, anger about a difficult client decreased when a worker was able to share the encounter with a group of peers (McCance et al., 2013). In a survey study, workers in hospital units who had the opportunity to express their "authentic" feelings with their unit coworkers about difficult patient encounters showed a negative association with burnout (A. Grandey, Foo, Groth, & Goodwin, 2012). Thus, when individuals engaged in people work are able to share their actual feelings about difficult client encounters, it influences how they interpret and experience EL. Closer to the setting of this article, a qualitative study of an ICU describes how physicians and nurses must constantly suppress their feelings to maintain control of the stressful family encounters that sometimes follow a patient's death (Sorensen &

Iedema, 2009). Despite this, the clinicians noted that the most difficult aspect of their work was lack of opportunities to process and share their feelings about these encounters, leaving them in what the author termed an "emotional cul-de-sac" (Sorensen & Iedema, 2009, p. 13). The study concluded that EL is not recognized as a competency in health care and is absent from ideal models of care and workforce development strategies. One way to flesh out how organizations shape the experience of EL, and how they might better support it, is to consider supervisor–employee interactions (Grant, 2013).

Subfields in psychology and management that focus on organizations have long explored the mediating value of supervisor/worker interactions in mitigating worker stress, but with little incorporation of the EL concept or issues specific to health-care workers. Research on the influence that supervisors have on worker well-being has focused on customer service occupations where there is ample evidence that supervisor support buffers the stresses of people work (Eisenberger, Stinglhamber, Vandenberghe, Sucharski, & Rhoades, 2002). For example, an early but frequently cited meta-analysis shows that supervisor support was an important feature of positive worker responses related to EL, though not all studies explicitly connected their findings to the concept (Kurtessis et al., 2017). One study that looked at the experiences of bank tellers found that those who were more positive about their work were also more likely to be employed in bank branches where the management was enthusiastically supportive of their service to customers (Schneider, 1980). Another study of call centers showed that worker experiences varied based on their supervisor and not the amount of EL associated with their role (Wilk & Moynihan, 2005). These studies suggest that a worker's experience is partly determined by supervisor behavior rather than by EL job demands.

While recent research suggests a similar role for supervisor support in medical settings, few health-care organizations seem to value EL enough to provide education and skill development opportunities to improve the experience of emotional regulation. For example, a study of NICUs found that nurses were required to attend in-service programs on a regular basis with regard to critical clinical skills, policies, and procedures but that educational sessions did not address EL or psychosocial coping skills (Cricco-Lizza, 2014). Even though individuals in caring and people work professions have the greatest potential to be rewarded by EL, organizations rarely offer opportunities for the processing and skill building that would support EL and protect against its negative outcomes. Moreover, studies do not explore this vacuum

and its consequences for workers and patients. In addition, not only does the psychological/management literature on EL not incorporate issues specific to health-care workers, but EL studies are based mostly on surveys, and the few that include qualitative data rarely describe worker–supervisor interactions. The absence of empirical data on worker–supervisor interactions is also an issue for work in sociology. In addition, although sociological studies are more likely to integrate the EL concept, they usually focus on worker–client interactions while ignoring the importance of organizational agents and processes.

For the most part, the sociological literature still reinforces notions of EL as negative and the responsibility of workers, rather than an organizational imperative, and the responsibility of management and supervisors to increase its efficacy. For example, though more recent work has tried to take into account how group dynamics shape the experience of EL, many studies continue to frame EL as manipulative, and therefore somewhat negative, while ignoring the import of superordinates (Francis, 1997; Thoits, 1996). Studies that explore the role of interactions that support EL sometimes focus on how workers provide support to one another after managing their emotions around their supervisors, as opposed to exploring how supervisors can support a worker's client-oriented EL (Lively, 2000). Finally, even when studies make more explicit the importance of organizational support for EL, the mechanisms by which organizational agents do or do not provide support remains underspecified. For example, organizational support for worker EL with clients is alluded to in a study by Lopez (2006) in which a nursing home is credited with promoting positive EL experiences. However, workers were simply shown a video at orientation that described how they should manage their EL with patients, with little formal ongoing support for their efforts. A study by Singh and Glavin (2017) goes further, measuring organizational support of worker EL across many occupations, but the metric is based on a survey that includes interactions with supervisors, clients, and other workers, with only 1 of 10 questions exploring worker interactions with superordinates. Thus, overall, the processing of worker–client EL with organizational representatives is given short shrift in the sociological literature. Although tending to focus on formal policy as opposed to interactional processes, some sociological studies have done a better job analyzing the role that hierarchy and leadership play in shaping the experiences and efficacy of frontline workers.

Research on organizational policy and leadership suggest that both have a powerful effect on whether or not worker EL with clients is

supported and that interactions between superordinates and subordinates are an important mechanism through which organizations shape EL. For example, Bolton's (Bolton & Wibberley, 2014) study of home care workers describes policies that allot time for physical care tasks, but not for the EL required to talk, nurture, and coax elderly patients to accept and participate in their care. The result is that workers often forgo certain patient services despite the fact that they are mandated by the organization. Thus, the notion that worker EL is essential and foundational to physical care is suggested but not supported by the organization. Although rare, there have been studies that have focused directly on worker-supervisor communication, with findings that show that said communication shapes worker–client experiences even though these studies do not explicitly address EL. For example, a study that explored organizational approaches to supervisor/worker interactions in 27 primary care practices found that when leaders used practice-wide meetings to encourage and reward information sharing about patients, staff knowledge, particularly from those lower down in the hierarchy, was made available to develop creative solutions (DiCicco-Bloom & DiCicco-Bloom, 2016). In contrast, when leaders were disrespectful of staff, denying them the opportunity to voice their concerns about patient care challenges, it had a chilling effect on information sharing and the staff's commitment to their work, which implicitly includes EL with patients (Schein, 2010; Weick & Roberts, 1993). In addition, although some studies suggest that in most occupations intense EL does not impair one's health (Singh & Glavin, 2017), the medical literature finds that increasing stress on frontline health-care clinicians is associated with not only health-related impairments but also a concomitant decrease in patient care quality (Shanafelt et al., 2012; Shanafelt, Bradley, Wipf, & Back, 2002). Given the growing, if fragmented, body of work suggesting the role of organizational and superordinate behavior on worker experiences, efficacy, and fulfillment, studies that have suggested, if only implicitly, the mechanisms through which supervisors do or do not support EL provide a stepping stone for our systematic analysis of the topic.

Qualitative studies that have explored what happens when caring professionals reach out for assistance with EL found that they are often discouraged and even chastised by those with organizational authority for attempting to garner empathy or support to improve their skills. For example, in the study of 911 dispatchers (Shuler & Sypher, 2000), an employee named Carol reports that when she reached out to get some feedback from a colleague about how she handled a

phone call with a woman who found her father after he committed suicide, the fellow dispatcher reported the conversation to their supervisor who then recommended that Carol seek counseling (Shuler & Sypher, 2000). In reflecting on the incident, Carol said:

> I hadn't thought about seeking counseling . . . I guess the problem [. . .] was discussing how I felt and how I handled the call. . . .You have to . . . suck it in and take it all and not express any kind of [self-doubt] . . . where does that leave me as a human? (Shuler & Sypher, 2000, p. 65)

In describing the need to once again repress her authentic emotions, only this time for the sake of a supervisor, Carol suggests that SEL is foisted upon workers by leaders and organizations. Moreover, it was not the EL with the caller that Carol found most difficult, but the expectation on the part of the supervisor that she not process her EL experiences at her workplace. By suggesting that she seek out counseling, the supervisor pathologized Carol and illustrated the organizational assumption that it is not the responsibility of superordinates to support and improve worker–client EL (Shuler & Sypher, 2000). In contrast, this article builds on an understanding of EL as a potentially positive experience, an essential ingredient of the quality of service offered by care work organizations, and thus a priority for organizational recognition and support. One way that organizations actively undermine worker EL is through SEL, a form of emotion management that is not central to the services of an organization, even if it might be seen by supervisors as a way to expedite their daily duties. Our conceptualization of SEL suggests that it is the responsibility of leaders to help make workers more effective in achieving the goals of an organization, and not to make life easier or more comfortable for themselves.

Methods

Setting: IDG Meetings

The setting for this study is a community-based hospice program, part of a division of home care, in a 369-bed general hospital located in an upper middle-income suburb in New Jersey. The hospice team includes registered nurses who serve as case managers, a physician medical director, certified home health aides (HHA; nurse assistants), social workers, a chaplain, and volunteers. An interdisciplinary team approach is required for federal reimbursement, and so patient care plans are

reviewed and updated every 15 days at IDG meetings to assess patient status, progress, interdisciplinary processes, and Medicare/Medicaid eligibility (Wittenberg-Lyles, Oliver, Demiris, & Courtney, 2007). Internal review board approval was obtained from both the hospital and from the first author's home institution. The first author signed a Health Insurance Portability and Accountability Act form agreeing that any access to patient information would remain confidential. In addition, all interview participants signed a consent form stating that any published data would be de-identified.

Data Collection

The data for this article were collected from June 2012 to August 2015 during which time the first author attended 43 IDG meetings, recorded field notes of observations, the number of EL and SEL episodes, the length of meetings, and conducted 20 qualitative interviews with supervisors, nurses, and social workers. There were two different hospice teams each with about 12 consistent members. Each team met on alternate Wednesdays at 8:30 a.m. Both team meetings had in attendance three social workers, five nurses, a chaplain, a medical director, an HHA supervisor, and a nurse supervisor who leads the meeting. All attendees were White and female, except on three occasions when a male chaplain filled in for the regular chaplain who was ill. The age range of social workers and nurses was 40 to 59 years. The supervisors were between 45 and 55 years. The team meetings were led by four supervisors whose tenure was between 8 and 12 consecutive months over the 3 years of data collection. After their supervisor tenure, only one supervisor left the organization while the other three took other staff positions. The investigator attended each teams' meeting with equal frequency. We did not differentiate between the teams because the dynamics related to EL varied by supervisor. Over the period of the study, the first supervisor supported EL talk, the second two imposed SEL, and the last supervisor supported EL talk. Observations were recorded as jottings during meetings and then transcribed into full-length field notes after meetings concluded. Interviews began with the question, "Tell me about your experiences working in hospice (nurse, social worker, or supervisor)," followed by probes to encourage in-depth descriptions of events and interpretations. Interviews lasted from 1 to 4 hours and were transcribed verbatim. All the participants were women, so we refer to the participants using feminine pronouns.

Field notes and interview transcripts were analyzed by the first author through the constant comparative method, in which codes are identified and labeled, which suggested the two opposing interactional social dynamics examined in this paper (Glaser, 1965). Then, the second author, drawing on abductive analysis (in which themes in the literature are compared with one's data and surprise findings are taken as a signal of potential contributions), suggested the theoretical framework, and both authors reviewed the literature to analyze the two sets of interactions in IDG meetings: one in which nurses discussed their EL and the other in which they were impeded by supervisors, which the authors' decided to call SEL (Timmermans & Tavory, 2012). The tension between these two dynamics is partly rooted in the contrast between the latent function of IDG meetings for EL processing and skill building, and their official purpose to review and update patient plans, document collaborative efforts, and determine patient eligibility for hospice (Fine, Davis, & Muir, 2014). In addition, as it became apparent that supervisors who imposed SEL were concerned that EL talk reduced the time nurses had to visit patients, the first author began to document meeting times to compare those in which EL talk was supported and those in which SEL was imposed.

Findings

The value of EL talk. Given the circumstances that usually bring patients and families to hospice, nurses often find themselves in situations where they must regulate their emotions, either through suppression (surface acting) or alignment (deep acting). Although our data suggest that nurses and social workers are more likely to talk about interactions that feature surface acting, our analysis does not attempt to differentiate between the two, and the literature suggests that both are used by individuals in the caring and service professions to bring about therapeutic ends.

In interviews, several nurses and social workers brought up issues related to EL and were probed about its occurrence and the response of IDG meeting participants. None of them could recall a patient/family encounter that did not involve, "managing [their] feelings and responding to help [families] with their distress," with a goal to "somehow make the situation better for patients and families no matter how they [the nurse/social worker] felt." Nurses and social workers spoke about the stress this created, that sharing their feelings about patient encounters with supervisors and colleagues helped, and that IDG meetings were the

"only opportunity" for this to occur. One nurse captured the sentiments of the others when she described talking about EL with clients at meetings:

> We keep it together when we are with patients, that's the job and we need to do that . . . sharing helps you gain some perspective to plan your next move for your patient with your team. It also helps when a supervisor acknowledges that you pulled it off. That feels good. [The supervisor] can help you figure things out for next time . . . Where else [can that happen] but IDG.

This nurse explains that EL is an important part of her work, and talking about EL at IDG meetings helps her do it. The meetings provide access to support, through team and supervisor feedback, which improve skills and guide planning for the future. The meetings also provide access to emotional support, such as when a supervisor acknowledges that she pulled it off.

Interactions in IDG meetings illustrate how supervisors can shape a work setting so that it provides emotional and informational support to workers sharing EL experiences. Observational data from IDG meetings demonstrate that the behavior of superordinates and colleagues can support those trying to talk about EL. In the following narrative, a nurse's eyes never leave her computer as she describes what happened when she visited a patient she was close to and realized that the patient was actively dying:

> *Ms. Falk (Nurse)*: I took the home health aide (HHA) to show her wound care. . . .When we got there I realized that [the patient's] death was imminent. She was very uncomfortable, we worked together and tried to make her comfortable and I sat [with the patient] for about two hours and I held her hand while she just stared at me. I kept telling her quietly, "it's okay to go, and rubbing her hand." After an hour I sent the HHA on [to another patient] after I reviewed . . . what to do for a patient who is near death. She is new and I could see [this] was hard on her. I think I did the right thing.
>
> *Supervisor:* I think sending [the HHA] to the next patient was an excellent idea. It was a good experience [for her] but it was a lot [. . .] it was good that she had her first experience like this with you.

Ms. Falk (Nurse): I stayed and bathed her and I combed her hair so that she would look okay for the family. I had to keep it together [. . .] I knew that the family was coming.

The group sat silently looking at the nurse who, jaws clenched, continued tapping on her computer.

Ms. Martin (Social Worker): "I am sure [the family] was comforted. I came after and she seemed so peaceful. You did so much for her."

Supervisor: "I heard from the Director that you did a great job. She doesn't usually give us good news so word got around. Thank you. When you are ready, I would like you to review with the group your approach to preparing the HHA to care for a dying patient."

Ms. Falk looked up and smiled weakly. Then someone remembered something funny that happened between her and the patient and the group laughed. After a pause, the next patient was discussed.

In these field notes, Ms. Falk describes how she was unexpectedly faced with an actively dying patient while overseeing an HHA who had never witnessed a patient death. Ms. Falk engaged in EL by regulating her feelings of loss and calmly soothing the patient. Her EL was not only for the sake of the patient but also for the HHA, who is learning how to care for the dying. After assessing the HHA's reaction, Ms. Falk expertly determined that it was best to send her along to her next patient. After this, she again "holds it together" and washes the dead woman for the sake of the family.

The sharing of EL experiences at IDG meetings provides nurses with the opportunity to receive informational and emotional support, and gives supervisors the opportunity to critique and validate a nurse's approach and provide education and reinforcement for beneficial behaviors among other health-care providers. Ms. Falk received informational support from the supervisor, who provided feedback by stating that sending the HHA to the next patient was an excellent idea. Then the supervisor provides emotional support by thanking the nurse for her effort on behalf of the hospice organization and its patients and staff. Ms. Martin, taking her cue from the supervisor, also provides emotional support when she describes the state of the patient and says, "You did so much for her." Sharing her experience and decisions at the IDG meeting allowed Ms. Falk to receive critical feedback and

acknowledgement, and her EL efforts were held up as a model for others.

EL can be used to skillfully promote the well-being of clients and patients and is central to the caring and service professions. Therefore, opportunities to process EL are crucial, not just for the comfort of the laborer, but because critical assessment of the process presents opportunities to educate those with less skill and experience, thereby contributing to the goals of the organization. SEL, on the other hand, robs the worker of this support and feedback, and the organization of the opportunity to establish EL standards.

Imposing SEL. SEL is a form of imposed emotional regulation that occurs when organizational representatives obstruct the attempts of workers to discuss EL. In the hospice program, SEL occurred when supervisors stopped nurses and social workers from talking about the EL they did with patients and instead insisted upon using IDG meetings exclusively for updates on instrumental and clinical issues. Although there are a variety of ways in which SEL can be imposed, we focus on two mechanisms: when a supervisor interrupts a speaker who is attempting to discuss EL experiences, and when a supervisor changes the organization of meetings to curtail EL talk. In the following scenario, Ms. Anderson (a nurse) describes how she avoided sharing her concerns with a family about a patient's continuing eligibility for hospice because of improvement in her condition. After Dr. Roberts (a physician) confirms this possibility, Ms. Anderson becomes upset and attempts to further discuss the issue, but a supervisor imposes SEL and stops the nurse's EL talk:

> *Ms. Anderson (Nurse-she is frowning and has a furrowed brow)*: What do you think . . . she has gained some weight? The family is assuming that she will stay on hospice. I have been positive and supportive and I have not told them that she might not be eligible [for another recertification period].
>
> *Dr. Roberts (Medical Director-looks up and speaks softly leaning towards the nurse while making eye contact)*
>
> I get it . . . but if she isn't losing weight we can discharge her and then if she declines we can take her back.

Ms. Anderson (her eyes widening as her face turns red): But what we did for her was control her pain. If we discharge her then her pain won't be managed, she will stop eating and she will deteriorate and then we will take her back but she will suffer and so will the family. I don't think I can stand that . . . it is . . .

The supervisor interrupts speaking cheerfully and smiling: Put on your big girl pants . . . we will take her back if she loses weight . . . its 10:00 and we are only half way through the list . . . these meetings are too long and I want to be done by 10:45 . . . whose next?

The supervisor never looks up from her computer and maintains a smile. Ms. Anderson clears her throat and glares at the supervisor, who calmly asks again in the same cheerful tone: "whose next?" . . .

The patient's social worker goes from sitting back with her arms relaxed at her side to sitting forward and grimacing, tapping her finger and staring at the supervisor, and says in a sarcastic tone: Well I guess we're finished with her?

The group is silent, some hunkering down in their seats and staring at the table; others make eye contact with one another. . . .The supervisor breaks the silence by naming the next patient. This is followed by a minute of complete silence.

In the earlier field notes, Ms. Anderson describes her experience managing the dissonance between her concern about a patient's future eligibility for hospice and her calm and encouraging display while with the patient's family. She talks about this EL in the hopes of receiving emotional and informational support from her supervisor and peers. Instead, we observe the imposition of SEL as the supervisor smiles and tells Ms. Anderson to "put on your big girl pants," intimating that her concerns about the patient are childish and do not warrant the attention of the group. Therefore, not only did Ms. Anderson have to suppress her concerns and feelings while with her patient, she also has to do so while with her supervisor, suppressing her desire to talk about her EL experience in favor of the supervisor's desire to focus solely on instrumental patient information. This episode of SEL was upsetting not only to Ms. Anderson but also to the other members of the hospice team, as demonstrated by their silence and stalling when the supervisor

asked, "whose next" and the resistance of the social worker when she sarcastically said, "Well I guess we're finished with her?"

Another strategy supervisors use to enforce SEL is to change the order of the patient categories reviewed during IDG meetings. For the first year during data collection, the order of review was as follows: patients who had died (bereavement), those who were newly admitted, those being evaluated for recertification, and then any others. During the second year, bereavement was moved to last. Bereavement often included the processing of EL, especially when the nurse or social worker was present during death. However, when bereavement review was made last, the supervisor leader left the meeting before the review was complete, suggesting a lack of support for the nurses' EL talk. In the following scenario, Ms. Burns, the bereavement social worker, names the first patient who had recently died as the supervisor leader prepares to leave. In response, the group members looked confused, and Ms. Burns speaks up:

> *Ms. Burns (Social worker leading the group)*: We are not through yet.
>
> *Supervisor:* Go ahead. . . .I have a meeting. You folks finish up.
>
> *Some individuals started to have side conversations.*
>
> *Ms. Reginald (Nurse):* Can I present my case . . . ? Mr. B had a difficult death and my final visit with the wife did not go well. I stayed calm but she was very upset and it was really sad and I am concerned about how [I] did and . . . is anyone listening?
>
> *Looking dismayed, Ms. Burns tries unsuccessfully to get the attention of the group as some proceed to leave. Finally, she gives up and just reads names to find out who needs phone follow-up and who doesn't.*

The supervisor's exit at the start of bereavement reduced the review to strictly instrumental decisions about how to proceed with phone calls or visits for closure. This decision denied nurses and social workers the opportunity to process their EL. The desire for this opportunity to process is highlighted when *Ms. Reginald* tries to talk about her interaction with the patient's wife and then asks "is anyone listening?" More broadly, the supervisor's exit reinforced a lack of regard for the EL of the staff, discouraging attention to their colleague's efforts. Thus, SEL was enforced by a supervisor using a more passive, if just as effective,

approach. During an interview, one nurse suggested that some supervisors do not care about their experiences with dying patients: "why should they; [patient] eligibility, the care plan, and reimbursement are no longer a concern, but what about what we go through?" This suggests that some supervisors do not consider EL to be an essential feature of the work.

Quantitative data. The distinction between support of EL talk and SEL motivated the decision to collect quantitative data to assess the number of meetings in which the former and the latter occurred, the circumstances influencing their emergence, and how long meetings that supported EL talk took when compared with those featuring SEL. An analysis of all meetings in the sample ($n = 43$) shows that those in which EL talk was supported are close to the number in which SEL was imposed. Twenty-three meetings featured a total of 72 episodes of SEL, while 20 meetings featured 45 episodes in which EL talk was supported. The number of episodes of SEL was occasionally greater during SEL imposed meetings when compared with episodes of EL during EL-supported meetings. This seemed to be because the imposition of SEL sometimes led staff to make multiple attempts to discuss the same patient, and the supervisor to repeatedly suppress the conversation. Each attempt, when separated by other patient reports, was counted as an episode. In addition, after SEL episodes, silence often ensued, and staff were slow to report on other patients. In contrast, when EL talk was supported, the meetings moved more quickly. Therefore, the assumption that addressing EL during IDG meetings consumed time that reduced the opportunity for nurses to see more patients is not supported by our data. A time assessment of the final 25 IDG meetings in which data were collected by the first author comparing those in which EL talk was supported to those in which SEL was imposed is presented in Table 1. Only three of the four supervisors were

Table 1. Comparison Between Meeting Dynamics—Support for EL Talk and Impositions of SEL.

Assessment of 25 meetings	Imposition of secondary EL	Support for EL talk
Number of meetings	14 (2 different supervisors)	11 (1 supervisor)
Range of meeting time	2 hours 45 minutes–3 hours 5 minutes	2 hours 30 minutes–3 hours 15 minutes
Average meeting time	2 hours 55 minutes	2 hours 40 minutes

Note. EL = emotional labor; SEL = secondary emotional labor.

observed during the 25 meetings during which the length of the meetings was tracked because the investigator did not start collecting this data until after the 18th meeting.

We were unable to do a statistical analysis (Wilcoxon rank-sum test) to determine the significance of the difference between groups in which EL talk was supported and those in which SEL was imposed because the samples are not normally distributed and were smaller than is recommended for such a test ($n_1 \geq 30$ and $n_2 \geq 30$; Wilcoxon, Katti, & Wilcox, 1970). Thus, while the descriptive statistics undermine arguments about how EL talk wastes time, the finding cannot be said to be statistically significant (though it is highly suggestive).

As shown in Table 1, the meetings in which EL talk was encouraged were, on average, shorter than when SEL was imposed. In addition, when SEL was imposed, almost all staff stayed after the meeting to informally process their EL with their colleagues for between 20 and 30 minutes. The absence of supervisors during these discussions amounted to a lost opportunity to better understand the staff's EL challenges, support the staff's EL efforts, and for supervisors to contribute their expertise to the staff's skill development. In contrast, when EL talk was supported, nurses and social workers usually left within 10 minutes.

Appeasing the staff while marginalizing EL talk. During the second year of data collection, in response to hospice staff complaints about not having time to talk about what they described as the "stress" of their work, a monthly support group, facilitated by a hospital social worker, was established for the teams to share their experiences. According to a supervisor, the meetings were set up to help the staff with their patient issues, giving them "a place to get it off their chests." A nurse described the dynamics that undermined the meetings, which ended up being canceled after only three sessions;

> There were several problems. [The meeting] was held during the afternoon, the worst time [. . .] you are seeing your last patients, finishing your notes and calling other team members [to discuss patients]. Our workload wasn't reduced for the day like they do with IDG [. . .] the supervisors weren't present so [they] couldn't address the issues . . . and the sense that this was therapy [. . .] we're not troubled . . . we don't need therapy. We need to talk about our work and we need [everyone] to be there.

This nurse suggests that the meetings failed because they treated EL talk as an individual pathology and not an organizational imperative. This was reinforced by (a) the absence of supervisors, (b) optional attendance, and (c) staff having to use personal time to attend. Moreover, the outsourcing of EL support was perceived by the staff as a diminution of their labor. In addition, it represents another example of SEL, as it provided a third avenue for supervisors to avoid providing informational and emotional support to workers.

Supervisor and staff views of EL talk. There was no apparent evidence that anything besides the administration's desire to shorten IDG meetings, with the goal of increasing productivity, shaped supervisor decisions to suppress EL talk. Interviews with the two supervisors who supported EL talk suggest that they thought it was an important part of meetings and thus resisted pressure by the administration to reduce its occurrence:

> *Supervisor 1: I think that's partly what [IDG] meetings are for. [Nurses] can't always say to patients what would be best for them. It wouldn't be good for the [patient/family relationships]. Although that's difficult, you can't push patients and families when they aren't ready. We have to work around [the issue], and I think that makes the staff feel that they are not giving proper care. We just had a patient die whose wife insisted on feeding him even though it caused [him] pain. She was afraid he would starve. When you are actively dying, food is the last thing you need. The nurse tried to tell them this, but they weren't able to listen. The nurse kept trying, but she had to go along even though the patient was throwing up and his bowel was distended so the nurse needed to talk about it at the meeting. Some [administrators] don't understand this. One administrator said, "the hospice team are the only people that have a part-time job that get paid fulltime . . . what other nurses or social workers get to sit in a meeting for 2 to 3 hrs. every week talking about feelings."*

A second supervisor who, over time, went from resisting EL talk (before this study) to supporting it described the evolution of her thinking about the importance of allowing staff to access emotional and informational support:

> *Supervisor 2: I used to be less supportive. Then I noticed that the staff, especially when things were really tough [with family/patient conflicts], they called in sick. Maybe they saved their sick days for those difficult*

cases. Then, at one meeting, the team insisted on letting a nurse share about a family that could barely afford food, but they kept refusing financial assistance and she had to just accept this despite her feelings. She was in tears. We came up with strategies for her to try. I told her she was doing a great job and about the things she was doing for the family. [With this] her requests for social work visits [to that family] lessened and she seemed more confident. The newer staff learned something . . . and referred to some strategies used by the nurse in [their] cases. After that I made time . . . Sometimes I get flak [from administration] because they think nurses don't see enough patients on Wednesdays, but we've lost some good nurses and I think [talking] helps us keep them.

This supervisor went from imposing SEL to supporting EL talk based on an experience in which a nurse benefited from support in the meeting, gained confidence, and was less dependent on other staff. The supervisor also says that making time for EL talk contributes to the retention of effective nurses, suggesting the organizational degradation associated with SEL. During another interview, a senior nurse was asked whether EL talk in IDG meetings was ever a poor use of time:

Senior Nurse: We tend to respect our time together. Off hand, I can only think of 2 or 3 times in the last few months when someone went on . . . and it was time to move on . . . then the supervisor told the nurse [she] could talk to her after the meeting to get more information. You learn pretty fast when it's time to stop [EL talk].

In another interview, a nurse describes the importance of EL talk with patients and the problem of SEL in IDG meetings. Her comments recount a particularly difficult period during which the processing of EL was adamantly discouraged for months:

Nurse: You have to understand that you have to be gentle about what you say and how you care for [dying patients] and their families. You have to hold back and not try to do too much, come on slowly. Sometimes you just can't do what you wish you could because the families can't take it. That's okay-we get that, but, when you need to talk at IDG meetings about these problems and the supervisor shuts you down, that really eats at you. You feel like the effort and the pain of it doesn't matter, but it's such an important part of the work. Also, I want to do this better and if we don't talk, we can't improve. You know . . . last year we had a supervisor who shut down talks. I took extra sick days and I know of another nurse who took a

medical leave and our meetings were part of the problem. She opted to have elective surgery just to take a break. There have been others.

This nurse characterizes the suppression of her feelings with patients as an important part of her job. What she can not abide is the lack of support from her supervisor to share and process her effort and pain. In describing her decision to take time off when EL talk was not supported in IDG meetings, the nurse highlights the broader cost of SEL for organizations that employ care workers and rely on them to regulate their emotions in ways that bring about outcomes which these organizations, at least formally, purport to value.

Discussion

Care workers are often drawn to their profession by a desire to navigate intimate, meaningful, and sometimes fragile relationships with clients, using empathetic strategies like the skillful suppression of certain feelings and responses and the careful selection and expression of others. EL constitutes a crucial component of the job of care workers, like nurses, as they promote and maintain the trust of their clients. Indeed, it is a central part of the therapeutic relationships that allow individuals and organizations to provide efficacious patient care. That being said, the intensity of EL can take a toll. In this article, we show that interactions between workers and supervisors mediate whether EL is experienced as a positive or negative attribute of care work. When supervisors withhold emotional and informational support from subordinates who wish to process their EL, workers must engage in another round of emotional management, what we term *SEL*. Our specific and unambiguous conceptualization of SEL provides clarity to an insidious and frequently occurring process that has remained undefined and only vaguely addressed in the literature.

We have described instances depicting evidence of supervisors foisting SEL on workers, in this case, hospice nurses, as well as the perceptions and experiences of workers that show how SEL undermines worker efficacy and the organizations they represent. We show how some supervisors impose SEL by stopping EL talk or by scheduling EL intense discussion categories (bereavement) for last and then leaving before EL talk could commence. However, despite the concern that EL talk takes too much time, data on meetings in which EL was supported took less time on average than meetings in which SEL was imposed. Moreover, when nurses and social workers were forced to postpone EL

talk until after meetings, patient visits were still delayed, and supervisors, not privy to the experiences of their staff, missed opportunities to provide support and guidance. Another consequence of imposing SEL may be nurse absenteeism or staff turnover, which requires nurses to cover for their missing colleagues and visit patients with whom they are unfamiliar. Although it cannot be determined whether nurses in this study suffered from impaired health, or whether absenteeism (e.g., elective procedures, illness) was directly related to SEL, there was agreement among the participants that it contributed to their stress and fueled a desire for respite. Data were not available to assess the economic cost of absenteeism because of illness or burnout, but previous medical research suggests they are related (Shanafelt et al., 2012). In addition, SEL was again imposed when supervisors, in an attempt to provide a (marginalized) avenue for EL talk, initiated a hospital social work-led group for nurses and social workers. By not taking part in these meetings, they underscored the lack of value attributed to EL by administration. Altogether, these observations suggest that the concept of SEL provides a valuable avenue to illustrating and exploring the role played by organizations and leaders in supporting (or undermining) the emotional skills that are central to care work and the efficacy of institutions which, at least purport, to provide and value it.

Unlike other concepts that operationalize worker stress by focusing on the individual, SEL draws attention to organizational interactions between workers and supervisors and how they shape the experience of EL. Concepts that seek to capture worker stress, such as compassion fatigue and burnout, tend to use surveys that measure worker *perceptions* of worker–client interactions, rather than analysis of actual interactions, particularly those between supervisors and workers (Patrick & Lavery, 2007; Slocum-Gori, Hemsworth, Chan, Carson, & Kazanjian, 2013). In addition, because concepts such as compassion fatigue and burnout draw attention to the subjective experiences of the participants, the interventions tend to focus on how workers can individually address their own distress outside of work rather than identifying workers distress as an organizational issue.

Denying care workers the opportunity to discuss their work-related EL can be explained in part by the finding that sharing emotions in the work setting is associated with organizational status and may be denied to lower level workers (Clark, 2007; Lively, 2000). This is suggested in the 911 study in which Carol's supervisor advised her to seek counseling, and it is implied in our study with the outsourcing of the hospital social worker group for nurses and social workers who "needed" to

talk. In both cases, the supervisors may have perceived the request by workers to share their EL as an inappropriate assertion; a request that, despite its contribution to their successful delivery of service, exceeded the allotment of organizational support and was arbitrarily deemed inappropriate by higher status personnel. That this assumption shapes management's understanding of EL as not worthy of the administration's attention and support is demonstrated when the supervisors implied that workers were dealing with an individual and therefore a personal issue, as opposed to an organizational imperative. In response, the nurses and social workers in our study stopped attending the meetings and expressed frustration that their EL work was not understood by some supervisors as an essential part of care, to be supported and developed within formal organizational structures. The concept SEL directs attention to potential oversights that can be addressed by organizational processes, such as the right of care workers to process their work-related EL through the integration of opportunities for supervisor EL feedback and skill development into the official workday, helping to alleviate the stress of EL by recognizing its value and enhancing its practice.

In addition to the contributions that this study makes to the EL literature, it also suggests important avenues for future research. First, although the authors included a review of the two most comprehensively explored dimensions of EL, deep acting and surface acting, it was not possible with our data to determine the boundaries between internal states—surface acting, deep acting, and nonacting—of the participants. For example, when a nurse expressed her concern about a patient's weight gain and its potential to result in discharge from hospice, she was probably expressing her actual feelings as opposed to regulating them for her audience. However, when the meeting's supervisor imposed SEL by telling the nurse to put on her "big girl pants" and the nurse glared at her, her behavior might have constituted surface acting (barely suppressing further communication about her feelings) or deep acting (working to align her feelings, though begrudgingly, to the supervisor's demands). However, we cannot be sure. Even more vague was the nonverbal behavior of those who sat silently and stared down at the table. They might have been engaging in deep acting (trying to align their emotions with the supervisor) or surface acting (suppressing their empathy for an outspoken colleague who was attempting to share her EL experience). Again, our data make it difficult to categorize the internal states of the participants as they responded to their superordinates. SEL is a new concept, and further research is required to gain insight

into the complexities of this abstraction and its relationship to the classic subconcepts of emotion management.

Second, although we identify the source of SEL as imposed by a superordinate, it is possible that peers may possess the personal power or seniority to impose SEL on their colleagues. Again, our data are limited to interactions among supervisors and workers at IDG meetings, so we were not privy to interactions exclusively between peers. Moreover, it remains an open question whether SEL, with its focus on organizational practice, should only be used to describe interactions between superordinates and subordinates, or whether peer-to-peer interactions, potentially a manifestation of a culture that does not support EL talk, is also relevant to the processes this article focuses on. A third avenue for future research is to examine SEL in other settings and organizations. This study is based on a hospice setting, an occupation with relatively extreme EL demands. However, there is precedence for developing concepts using extreme cases where evidence is exaggerated, allowing investigators to explore the various dimensions of an emerging concept. Lastly, the members of the hospice team were all White woman between the ages of 40 and 59 years. Therefore, we were unable to assess the implications of gender, race, or generational variance in the dynamics among the hospice team members.

Conclusion

SEL is a concept that describes a specific process limited to supervisors and workers, and yet our findings and studies of ICUs, NICUs, call centers, and 911 dispatchers suggest that SEL reflects an organizational dynamic that has transferability and plays an important role in the processing of EL, the well-being of employees, and desirable outcomes for organizations (Cricco-Lizza, 2014; Shuler & Sypher, 2000; Sorensen & Iedema, 2009). The formal integration of EL talk into routine meetings between supervisors and frontline workers is an overlooked resource, having the potential to improve the experiences and skills of those engaged in people work. EL is an important component of human service work, especially for those who care for the most vulnerable populations. The absence of formal and routine opportunities to enhance this skill undermines its legitimacy and execution. This oversight may be responsible for poor production and high turnover that wastes organizational resources. Beyond hurting workers, it may also deprive their clients of the best possible care, an outcome that

organizations can avoid if they focus more attention on supporting the EL that is central to their mission.

The hierarchical and patriarchal culture of health-care institutions can reinforce the behaviors of administrators and supervisors who deny nurses and social workers support for important, but often fraught, EL with patients, negating the fact that EL is foundational to care work. This is further reflected in the organizational and health-care literature that has not, to date, made a connection between the specific EL experiences of care workers and their care of patients/clients. SEL makes an explicit connection to the treatment of workers around their EL with patients and the potential hazards workers face in attempting to process their strong emotional experiences. Hospice nurses in this study and in general are often experienced employees with personal authority, as illustrated by those who expressed resistance when their EL talk was discouraged and SEL was imposed. In contrast, nurses and other workers who do not have the authority or job security to resist SEL are at the mercy of supervisors who impose it, and some are likely to mimic SEL and related behaviors when given the authority because these may be the organizational norms in which they are immersed.

Thus, efforts to change health-care settings requires the formal integration of policies and structures that do not just offer arbitrary opportunities to share one's EL challenges, but actually require it. Unfortunately, those with the authority to guide this process often do not have the skills to assist workers in their efforts to engage in effective EL with patients. As we saw in our study, if supervisors are inclined to impose SEL, it is likely that they are not only trying to be more efficient with time, but they may be uncomfortable with their own experience of EL and therefore are unable to help workers effectively process theirs. Supervisors need to be role models for expressing their own EL when they assist or supplement care services or supervise a worker. This can encourage workers to share their EL and not feel diminished by the experience. While past research has illustrated the power that leaders have to enforce or undermine interactional patterns which support EL talk or deny it, along with other elements that together represent the collective intelligence of an organization, there continues to be far too little research into how supervisors and organizations design and protect such opportunities (DiCicco-Bloom & DiCicco-Bloom, 2016). Thus, supporting and educating supervisors and managers to understand the importance of processing their own EL is the first step toward establishing

methods to facilitate this undertaking with the workers they supervise. This can go a long way to establishing healthier organizations.

Author's Note

The authors' names are listed in alphabetical order for convenience. This was a fully collaborative effort.

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