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I am submitting herewith a dissertation written by Stephen Spates entitled "Exploring Workplace Connections of Employees with Multiple Role Expectations: Accommodating Communication Behaviors of Hospital Chaplains." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Communication and Information.

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Exploring Workplace Connections of Employees with Multiple Role Expectations:
Accommodating Communication Behaviors of Hospital Chaplains

A Dissertation Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Stephen Spates
August 2017

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ABSTRACT

The purpose of this study was to explore the communication behaviors of hospital chaplains in an effort to understand their workplace role. In the literature, most chaplain recognition related to spiritual interactions and improved health outcomes for patients, which left much information about their workplace lives unknown. This study used interviews with hospital chaplains to explore their communication behaviors. Using communication allowed chaplains to manage roles and uncertainty, build relationships, and handle the paradoxical interactions they encounter at work. The findings revealed that hospital chaplains, who operate as liaisons in their organizations, practiced convergence to accommodate others. They also managed the stress of dealing with a job where they are always in demand, but also undervalued by others with whom they work. The implications extend communication accommodation theory's utility in the workplace. Future research should look at exploring the role of the chaplain from their co-workers' perspectives.

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CHAPTER ONE: INTRODUCTION AND GENERAL INFORMATION

Monday: Sat this morning with a woman whose newborn was downstairs in the NICU. After giving birth in the early morning hours and almost dying, the doctor recommended she have her tubes tied to prevent another pregnancy. We had a long discussion about how birth control was against her religious beliefs and how you could balance that with a benevolent God who would not want her to put her own life at risk. Left there and went to the Monday Administrative meeting. I am always amazed at how we can spend two hours talking and accomplish absolutely nothing. This was the first one of the month so it included all of the financials—nap time! On my way to lunch, I got paged to the ER for a multi-car crash. As the EMTs rolled the patients in, one of the nurses recognized a child from her neighborhood. She just about lost it. Went over and took her on a diversionary walk down the hall to check on another patient. Had nothing to do with the patient and everything to do with the nurse. As I was leaving the ER after all talking to all of the accident patients/families, I ran into a doctor from oncology and we caught up on the CHICAGO FIRE, MED, PD series. We like to see who can catch the most deviations from reality. Lost this one as I missed three that she found. Maybe tomorrow will be a calmer day . . .

The hospital atmosphere provides unique opportunities for interaction when considering the hospital chaplain role. Chaplains, employed by the hospital, have a unique purpose and expectation in their work environment. These employees become the only individuals who interact with everyone in the organization: hospital administrators, nurses, volunteers, social workers, patients and their families, physicians, and service workers. More importantly, these interactions may be informal (e.g., social conversation or meeting) or formal (e.g., scheduled meeting or prayer service in the chapel) communication.

In addition to their daily tasks of providing spiritual care to patients and employees, hospital chaplains participate in interdisciplinary team meetings made up of individuals from different organizational units. Teams foster more effective decision-making for the organization. Although hospitals have several different departments, these departments do not interact frequently with each other, which makes interdisciplinary teams necessary as decisions affect all departments. For example, decisions about how to implement security procedures to protect patients and their privacy affect all organizational members who work with patients as well as those who take care of the hospital environment, including cafeteria staff and cleaning/maintenance personnel. Since most of the individuals on this interdisciplinary team are medical professionals, chaplain contributions are valuable for two reasons. First, chaplains' views of health include spiritual health, individuals' ability to cope or be at peace with their current health status. Second, chaplains' interactions with all departments make them useful resources when meeting discussions take place. For example, in a meeting with hospital administrators on budgeting for nurses, chaplains are useful for explaining the nurses' needs to patients and their families. As a result, chaplains contribute beyond their stereotypical role of spiritual care and play an organizational liaison role. Liaisons, for this study, are individuals who interact frequently with all departments in the workplace and/or serve as a bridge to connect two or more departments. The study's objective is to examine the communicative behaviors of the hospital chaplain roles by exploring their daily interactions.

As people who interact with a very diverse group of others, they likely spend much of their days engaging in communication accommodation. As the opening journal entry created from various stories chaplains have told illustrates, chaplains accommodate as they move from one situation and stakeholder group to the next. For example, the patient interaction requires the

chaplain's theological expertise in conjunction with a compassionate style. The staff meeting, with many notes provided, uses less listening energy and an organizational jargon associated with the hospital's financial status. As a friend and co-corker, the chaplain can meet the nurse's needs by taking her on a meaningless walk down the hall and give her the time necessary to regroup before entering the trauma situation in full professional mode. Finally, the interaction with the doctor shows how the chaplain must also be able to communicate in an informal manner to build rapport.

Theory

Initially called Speech Accommodation Theory, social psychologists wanted to improve the evaluation of variations in the language in different social environments (Gallois, Ogay, & Giles, 2005) and explain how people alter their speech depending on the person with whom they are speaking (Giles, 2008). People use the theory to help make sense of the mental and emotional processes that cause communicative convergence and divergence (Ayoko et al., 2002). Over time, the theory expanded to consider the social consequences and motivations of verbal and nonverbal communication in both the interpersonal and intergroup settings as well as a wider range of linguistic features, such as speech rate, pauses, utterance length, pronunciation, and nonverbal features such as smiling and gaze. To represent these changes in the theory's focus, the name changed to Communication Accommodation Theory (CAT) (Giles, Coupland, & Coupland, 1991).

According to CAT, three key goals underlie accommodation: a) evoking the addressee's social approval, b) promoting communicative efficiency between interlocutors, and c) maintaining a positive social identity (Beebe & Giles, 1984). Of the three goals, the first two (gaining social approval and communicating efficiently) relate mainly to convergence and the

third (maintaining a positive social identity) to divergence. These goals are essential to understanding why an individual would intentionally change, or maintain, their use of language.

CAT attempts to account for the motivations underlying speech style adjustments toward (i.e., convergence) or away from (i.e., divergence) a speaker's style. Convergence (a.k.a. accommodating behaviors) is a strategy by which speakers adapt to each other's speech and other communicative behaviors, such as modifying their accent toward other speakers or mirroring nonverbal signals (Baxter & Braithwaite, 2008). Similarly, divergence (a.k.a. non-accommodating behaviors) involves performing communication behaviors that highlight differences or cause separation between individuals. Divergence also occurs when someone does not trust or respect the other person or group involved in the interaction (Willemyns, Gallois, and Callan, 2003). When communicators are being accommodative and symmetrical, the results are generally positive and the relationship becomes stronger. However, when both parties behave in a mutually non-accommodative way or at least one party behaves in a non-accommodating manner, communication can become negative and tense. Because hospital chaplains deal with so many different people each day, their ability to accommodate plays a vital role in their personal and organizational success.

Hospital Chaplains as Spiritual Providers

Professional chaplains provide spiritual care to others in a variety of environments (e.g. hospital, military, university campus, government). The organizations they serve may also employ these individuals. While some professional chaplains are associated with certain denominations, others train to work with multi-denominational communities. Certification as a professional chaplain is a standard recognition process for all professional chaplain types. To become certified, chaplains undergo a process developed by the leading chaplain associations

across the United States. Qualifications include a master's degree in theology, an endorsement by a religious-affiliated community, 1600 hours of Clinical Pastoral Education (CPE), and an in-depth interview with a peer committee. CPE is an education model used to train each individual chaplain according to the objectives set by the program committee (Jankowski, Handzo, & Flannelly, 2011).

Chaplaincy, as a profession, occurs at a time when patients and patient-centered care are growing approaches to healthcare (Christopher, 2010). Patients are taking a more proactive approach to managing their health and interactions with physicians (Mohammed, et al. 2016). As they continue to take more control over their care, patients prefer to make more decisions about care when consulting spiritual guides (e.g., chaplains). Spirituality, therefore, becomes an important consideration for what kind of care to request/receive and what approach to take for certain diagnoses. In response to this demand, national surveys of hospital staff, chaplains, administrators, and program directors illustrate the wide range of roles that U.S. chaplains perform in their profession (Flannelly, Galek, Bucchino, Handzo & Tannenbaum, 2005; Flannelly, Handzo, Galek, Weaver & Overvold, 2006; Flannelly, Handzo, Weaver & Smith, 2005; Galek, Flannelly, Koenig & Fogg, 2007; Galek, Vanderwerker, Flannelly, et al. 2009). According to the surveys, hospital chaplains engage in a combination of the following behaviors: emotional support, religious services and rituals, advocacy, community liaison/outreach, ethical consultation, liaison to local clergy, integrate spiritual care into the organization, and handle directives/medical donations. Interestingly, these articles use the term liaison to indicate that the hospital chaplain connects the hospital to the outside community, not necessarily that the chaplain carries information between the two groups.

Hospital Chaplains as Liaisons

Hospital chaplains serve as organizational liaisons as defined for the current study. Several components help identify and describe the role of the organizational liaison (Jacobson & Schwartz, 1977). Their work looks at individuals within university departments and utilizes environmental working structure to identify liaisons. As a result, liaisons bridge different departments, hold credibility and expertise, and communicatively interact with multiple co-workers on a consistent basis. Hospital chaplains bridge different departments as they sit on different committees, known as interdisciplinary teams (Wittenberg-Lyles, Oliver, Demiris, Baldwin, & Regehr, 2008). Daily communication interactions make liaisons effective within their organizations (Jacobson & Schwartz, 1977). Therefore, communication should receive more research attention to understand how these liaisons contribute to the effective functioning of everyday workplace life.

Hospital chaplains are able to roam all areas of the hospital without others labeling them as intruders. As a result, they are able to communicate regularly with individuals from different departments within the organization. While they can access every corner of the hospital, they may or may not serve as a traditional conduit who brings or transfers information from one group to another. For example, nurses interact with physicians and families. They often serve as the conduit as the doctor may provide them with information to convey to the family; similarly, a family may provide the nurse with information that they are unsure of how to deliver to the doctor. In both of these cases, the nurse is a clear bridge or conduit for information (Apker, Propp, Zabava Ford, & Hofmeister, 2006). Unlike nurses, hospital chaplains may serve as informal bridges by sharing information from interdisciplinary meetings at which not every unit

has a seat; they may also take information back to the interdisciplinary meetings that they have informally gathered during their daily interactions with others in the organization.

Another identifiable factor is that chaplains hold credibility and expertise within their hospital organization. These individuals, as employees of the hospital, must meet organizational and individual expectations for others to perceive them as effective (Wittenberg-Lyles, et. al., 2008). In other words, chaplains are capable of completing their job and contributing to the interdisciplinary teams on which they work. In addition to their expertise, they are credible as sources of information for spiritual counseling and community-related provisions (e.g. social workers, family counseling, or specific denominational guidance).

Finally, chaplains as organizational liaisons often communicate with multiple individuals within the organization on a daily basis (Jankowski, et al., 2011). For example, a physician may interact with patients and families, medical professionals, other physicians, and administrators. However, a chaplain's interactions, on an average day often include patients and families, social workers, nurses, janitors, service workers, volunteers, community clergy, and specialized departments such as radiology and Intensive Care (Spates, 2014). While any combination of organizational sub-groups could show the point, this is a singular example of the significant volume and situational differences that occur on a regular basis.

Communication between co-workers is the most standalone component of the three factors. While other workers in the organization may have credibility or expertise in their specific field, high amounts of communication between different co-workers identify liaisons. As a result, chaplains serve as liaisons in the hospital organization due to their consistent communication interactions with and among diverse co-workers over extended periods.

Rationale

Hospital chaplains use communication in their role to interact with patients and their family members, co-workers, administrators, community professionals, service workers, and volunteers. Since organizational roles vary in complexity and they enact a multi-dimensional role, it may be necessary for hospital chaplains to use verbal and nonverbal accommodation strategies to manage their different interactions. For this study, chaplains' communication behaviors are the mechanism for exploring how they manage interactions, primarily with their co-workers. Because chaplains interact with so many different types of individuals in the hospital environment, they need language and terminology variations to achieve shared meaning.

The accommodation process concerns both speakers and listeners. Hospital chaplains engage in upward, horizontal, and downward communication, all of which are places where they engage in both speaking and listening to accommodate the needs of themselves and others. While we generally associate hospital chaplains with accommodating behaviors, both accommodation and non-accommodation can be mutual and symmetrical (Gallois & Giles, 1998). In one way, speakers need to be able to accommodate, or in other words, adjust their speech to reach shared meaning with specific listeners in different kinds of contexts. Additionally, listeners need to accommodate, which would be to develop tolerance of language adjustments from different types of speakers and adjust their expectations accordingly (Ayoko, Hartel, & Callan, 2002). Hospital chaplains devote significant amounts of time to listening, and not just to speaking, so it is equally important for them to understand those with whom they speak as it is for those individuals to understand them.

Listening is an important component of providing support (Bodie, Vickery, & Gearhart, 2013); in their spiritual role, chaplains provide support not only for patients, but also for staff and

family members. They also have a multi-dimensional job description, including spiritual and non-spiritual responsibilities and expectations set by hospital administrators. Chaplains are not only part of an interdisciplinary hospital team, but also the only significant contributors to social and emotional support for patients, staff, and family members.

In addition to providing social support, chaplains participate on interdisciplinary teams where they carry a unique perspective that places them outside of the cognitive priorities of hospital employees and medical staff. Those trained in the medical profession prioritize the results of health outcomes by a patient's physical well-being over anything else. However, when it comes to a patient's well-being, chaplains consider patients' spiritual wellness and ability to cope with their current physical condition as a positive health outcome, even if the prognosis is bleak (Flannelly, et al., 2005).

The hospital chaplain's role can become an interesting piece of the organizational structure—this person connects with each department in the hospital, and even those in the community who work with the hospital (e.g., social workers and community clergy). On a given day, these liaisons may interact with any combination of departments. In addition, they must be able to effectively communicate and interact with the community, families, visitors, and patients who are not part of the formal organizational structure. This creates a unique opportunity as they now hold a multi-dimensional role that requires high levels of communication, involvement, and identification (Pesut, Sinclair, Fitchett, Greig, & Koss, 2016). How chaplains maintain and manage these relationships affects the entire organization's identity and may be helpful in better understanding how organizational members communicate (Rodrigues Yim, 2000).

The purpose of this study is to investigate the communicative relationship between liaisons (hospital chaplains) and hospital employees/visitors and better understand workplace

communication processes. Based upon theory and previous research, chaplains are likely to engage in both communication accommodation and liaison functions. Thus, hospital chaplains as liaisons in their workplace environment help illustrate the internal structure of the organization as a whole. The implications of this study have the potential to extend current research on workplace communication behaviors in the field of organizational communication. To explore the purpose, the following research question guides data collection and analysis:

RQ1: How do chaplains communicate at work?

CHAPTER TWO: REVIEW OF LITERATURE REVIEW

Chapter one lays the groundwork for examining how chaplains communicate at work. This chapter provides a more in-depth summary of research associated with each of the study's constructs. The literature review discusses communication accommodation theory, spirituality/religion and health, and social support and spiritual care. From here, the literature review shifts to organization literature on role switching, and liaisons.

Communication Accommodation Theory

Giles, a linguistics and psychology professor at the University of California, developed the communication accommodation theory in the 1970s by focusing largely on intercultural communication (Gallois, Ogay, & Giles, 2005). At the theory's conception, Taylor, and Bourhis (1973) examined speech accommodation between bilingual speaking individuals to show that higher effort in accommodating to the other increases positive perceptions of the speaker. Convergence increased perceived attractiveness, intelligence level, and interpersonal investment with the other individual (Giles, Mulac, Bradac, & Johnson, 1987, Scotton, 1988). William Gudykunst (2003) analyzed a variety of intercultural communication phenomena. Gallois, Giles, Jones, Cargile, & Ota (1995) used CAT extensively in their research on intercultural communication, and updated a version of the theory to include 17 propositions regarding convergence and divergence within intercultural conversations.

While examining face and identity concerns in law enforcement situations, Giles, Willemyns, Gallois, and Anderson (2007) developed four key principles for CAT to help conceptualize communication and argued that these principles easily applied to interpersonal and organizational communication. The first principle stated that a speaker's level of accommodation

continues to increase the more they wish to show positive face and empathy; gain approval, respect, cooperation, and trust; and point out similar social identities. Accommodation also increases if someone is trying to neutralize a possible negative situation. The second principle focused on the effects that perceived positive accommodation has on the recipient, increasing the person's self-esteem, job satisfaction, and favorable impressions of the speaker. The third and fourth principles looked at non-accommodation issues: speakers' non-accommodation increases the more they wish to show their dissatisfaction with, and disrespect for, the other person's attitude, actions or social identities. Finally, the non-accommodation recipient evaluates the behavior as impolite, and may react negatively.

Interpersonal Communication. Within interpersonal communication, CAT research examined a variety of contexts, including intercultural communication, doctor-patient communication, family relations, and communication with strangers. Communication accommodation theory, often used in intercultural communication research, described the conscious efforts made to bring people of different cultures together through language adjustments (Rogerson-Revell, 2010). People viewed foreigners more favorably when they attempted to accommodate the other person's cultural communication characteristics. In healthcare, CAT models explained doctor-patient interactions, such as how patients perceive the behavior of healthcare workers more positively when the doctor accommodates to the patient (Watson & Gallois, 1998). Patients connected those accommodations to liking, satisfaction, and trust. Similarly, Harwood (2000) found that accommodation factors predicted satisfaction, liking, and closeness in grandparent-grandchild relationships. CAT clarified differences in communicative behaviors in men and women with same-sex and mixed-sex dialogues, as well as between strangers and spouses (Fitzpatrick, Mulac, & Dindia, 1995). Both men and women

tended to accommodate toward opposite-sex strangers, especially more attractive ones, with women accommodating most to male strangers and men accommodating most to their wives (Giles, 2008). While CAT effectively explicated a variety of interpersonal communication phenomena, the theory also held true in a wide range of organizational contexts (Giles, et al., 2007).

Organizational Communication. Willemyns (2003) applied CAT specifically in an organizational context. He described five studies, using various qualitative and quantitative methods, which analyzed interpersonal and intergroup communication in supervisor-supervisee work relationships. Results showed intergroup dynamics being significant in the unsatisfactory encounters, whereas interpersonal dynamics were significant in the satisfactory encounters, which supported the use of the theory in analyzing the variables in this setting. Perceptions of the other stemmed from people's need for respect and value. Similarly, Richmond and McCroskey (2000) found that supervisees had high perceptions of their supervisors when accommodation existed. In other words, when supervisors adjusted to their supervisees' expectations, both individuals were able to benefit from a more productive work relationship. Regarding sex differences, Willemyns (2003) found that employees perceived female supervisors in satisfactory communication as more accommodating than male supervisors, yet they were more dominating than male supervisors in unsatisfactory interactions were. Also, male supervisors showed they value their employees more than female supervisors do. Interestingly, supervisees accommodated to their supervisors more than the other way around as lower status individuals gained more from being accommodating. Overall, Willemyns' (2003) research showed the importance of supervisors understanding the effects that their communication style can have on their employees' perceptions of them.

In the international business context, Rogerson-Revell (2010) explored the ability of native English speakers and non-native speakers to relate while working together.

Communication was more effective when speech accommodation helped non-native speakers understand the messages. More importantly, the perception of productivity and satisfaction with co-workers was higher with speech accommodations. Similarly, proper use of discourse improved group productivity and management. Individuals were also able to manage group task conflict better (Ayoko, Hartel, & Callan, 2002). Using language and discourse as strategic tools for divergence allowed individuals to highlight differences between co-workers and exclude certain individuals.

Sociolinguistics. Outside of common communication contexts, Giles, Coupland, and Coupland (1991) used the theory in sociolinguistics. Trudgill (1986) focused on CAT with language contact and dialect, and Giles and Williams (1992) used the theory to look at hypercorrection, just to name a few of the researchers who have given CAT consideration over the years. Littlejohn (1999, p. 107) described CAT as “one of the best-developed theories relating to interpersonal adjustment,” suggesting the theory will continue to attract new scholars and be widely used in future research.

Spirituality, Religion and Health

George, Larson, Koenig, and McCullough (2000) proposed three mechanisms by which religion affected health: religious practices increased healthy behaviors, coherence, and social support. First, religion increased healthy behaviors either by specifically prohibiting certain at-risk behaviors, such as alcohol and tobacco use, or by promoting a view of the body in terms of spiritual significance. Second, the health benefits of religion adhered to the coherence hypothesis, which proposed that “religion benefits health by providing a sense of coherence and

meaning so people understand their role in the universe, the purpose of life, and develop the courage to endure suffering” (George et al., 2000, p. 111). Third, religious participation facilitated social support by developing social bonds outside of the family for use during difficult times.

Mueller (2004) defined religious involvement as “the degree of participation in or adherence to the beliefs and practices of an organized religion” (p. 223). Spirituality, generally regarded as a broader concept, encompassed “one’s relationship with transcendent questions that confront one as a human being and how one relates to these questions” (Sulmasy, 2006, p. 1386). Past research looked at the connection between spirituality and improved health outcomes, but much of the research focused on faith rather than the chaplain (e.g. Christopher, 2010; Mueller, 2004; Puchalski, 2006). While conceptually distinct, spirituality and religion collectively improved physical and mental health outcomes (for key studies, see George, Larson, Koenig, & McCullough, 2000; Koenig, 2001, 2009; Powell, Shahabi, & Thoreson, 2003). Spiritual beliefs helped patients cope with illness by offering strength, hope, control, and acceptance as well as meaning and purpose in the midst of suffering (Puchalski, 2006). Further, knowledge about the relationship between spirituality and patient health outcomes would facilitate “health education, promotion, and counseling efforts across disciplinary boundaries associated with health communication” (Parrott, 2004, p. 1).

Spinale, et al. (2008) explored the relationships among spirituality, social support, and patients with End-Stage Renal Disease (ESRD). Results showed that patients who identified as spiritual people had a higher level of perceived social support. Although the relationships were not strong, the results showed that spirituality did play a role in survival with ESRD patients. Christopher (2010) observed the relationship between nurses’ personal religious beliefs and their

willingness to let end-of-life patients control conversations about their care. Results indicated that nurses with high intrinsic religiosity were more willing to allow patients to control end-of-life conversations. Spiritual beliefs help patients cope with illness by offering strength, hope, control, and acceptance as well as meaning and purpose in the midst of suffering (Puchalski, 2006).

Chaplains, with their unique healthcare perspective, disagreed with the biomedical worldview “restoration,” in which a successful outcome is one that restores a patient to his or her previous condition by overcoming the illness (Mandziuk 1994; Spohn 1996). If restoration did not occur, these professionals viewed it as a medical failure (Emmett & Schermerhorn 1974). The chaplain’s worldview focused on a bigger picture and acknowledged that human illness, though often chaotic, involved a spiritual journey. Therefore, the chaplain did not view worsened medical outcomes as failures, but as part of a journey that brought peace and wholeness to the patient (Shook & Fojut, 2004). Some hospital chaplains clearly felt they were integral members of the interdisciplinary team (Brock & Nelson, 1991; Gibbons & Miller, 1989; Mandziuk 1994; Mason 1990; Rodriguez 1996), but Shook and Fojut (2004) found some chaplains did not share that view.

Most health professionals recognized the important role chaplains play in dealing with end of life and providing for the spiritual and emotional support of patients and family members (Flannelly, et al., 2005). However, to varying degrees, they were less inclined to think chaplains should perform functions that chaplains themselves believed they were trained and able to do (Galek, Flannelly, Koenig, & Fogg, 2007). Many healthcare professionals were unaware of the comprehensive training regarding patient care that certified chaplains completed. These trainings prepared chaplains not only to perform spiritual rituals and services, but also to work with

patients and their families to provide emotional support, community outreach, ethical consultation, and advocacy. Chaplains, underutilized in some of these areas (Flannelly, Galek, Bucchino, Handzo, & Tannenbaum, 2005), found it difficult to make their abilities known. Team member in-service education about what chaplains could contribute would enhance the work lives of everyone involved. Furthermore, overwhelmed staff members and the increasingly impersonal medical environment created an opportunity for the chaplain to put a “human face” on the hospital by attending to the needs of families and patients (Mandziuk 1996).

Social Support and Spiritual Care

Schaefer, Coyne, and Lazarus (1981) outlined three primary types of social support: emotional, tangible, and informational. Emotional support “includes intimacy and attachment, reassurance, and being able to confide in and rely on another” (p. 385) to an individual feeling cared for and loved. Tangible support was providing direct services and resources, such as financial assistance or time. Informational support included assistance with defining, understanding, and coping with difficult events (Cohen & Wills, 1985). Spiritual and religious practice enabled an individual to engage in a relationship with a supportive other (God, higher power, and/or spiritual community) who gives emotional, tangible, and informational support (Peterson, 2011).

Albrecht and Goldsmith (2003) contended that social support aimed to help individuals cope with incongruities of existence, part of living a quality, healthful life. Social support, at its core a communicative process, involved “engaging in supportive interactions is an enactment of the need for human connection and meaning” (p. 264-265). From a health communication standpoint, support from others became crucial to helping individuals manage uncertainty and achieve a sense of perceived control to improve well-being during illness (Bisconti & Bergeman,

1999; Brashers, Neidig, & Goldsmith, 2004). Accordingly, research linked social support to positive health outcomes for cancer patients, as well as vulnerable populations, such as low-income pregnant women (Albrecht & Goldsmith, 2003). Likewise, researchers linked mental and physical health outcomes to spirituality, because of social support (Peterson, 2009). Women living with HIV shared how spirituality helped them (a) develop meaning and gain perspective; (b) receive emotional support; (c) assert control through a more powerful being; and (d) connect with a community. Participants' meaning and perspective resembled features of social support (i.e., the process of appraising information) that helped with coping.

According to uncertainty management theory (Brashers, et al., 2000), people sought to maintain, increase, or decrease uncertainty by information seeking and information avoiding. They reacted to uncertainty based on the meaning assigned to it, appraising the situation as either danger or opportunity and then experiencing corresponding emotions (Thompson & O'Hair, 2008). Feelings of anxiety and distress accompanied a danger appraisal, whereas hope and optimism accompanied an opportunity appraisal. Social support assisted with information seeking and avoiding, and encouraged reappraisal of uncertainty (Brashers, Neidig, & Goldsmith, 2004). Supportive communication increased, decreased, or maintained certainty and uncertainty for breast cancer patients (Ford, Babrow, & Stohl, 1996). Breast cancer survivors who perceived more support experienced less uncertainty, leading to additional social support and a higher quality of life (Sammarco, 2001). Breast cancer survivors who reported a wide network of support also report low levels of uncertainty (Wonghongkul, Moore, Musil, Schneider, & Deimling, 2000). The links among social support, uncertainty management, and health outcomes appeared most prevalent within breast cancer research.

Brashers, et al. (2004) found that social support played an important role in managing uncertainty. Dealing with medical uncertainty (living with HIV), they observed that patients had an overall better quality of life and were able to use social support as a key coping mechanism. Similarly, Scott, Martin, Stone, and Brashers (2011) found that organ transplant patients used social support as a way of coping with uncertainty. These patients were able to use the help of family and friends while in recovery to reduce the amount of uncertainty they had about their medical information.

Although past research focused on end-of-life patients and palliative care (Keely, 2007; McClain, Rosenfeld, & Breitbart, 2003; Quill, 2000), little research addressed the role of trained spiritual staff, such as hospital chaplains. For example, Keely (2007) found final conversations between dying patients and their families related to spiritual issues 67 percent of the time. However, chaplains enacted a variety of other roles including administrative, crisis management, and family counseling that were not included in the study.

Role-switching

Hare's (1999) research in small group communication looked at the development of roles in workplace environments where an individual's role may be consistent over time. However, the author noted that roles developed where the individual maintained several roles in the workplace due to their experiences and previous interactions (Hare, 2003). The way these roles unfolded brought to light the process of role development within organizations. Role differentiation, a strategy for individuals managing multiple roles to keep up with responsibilities, referred a person's ability to know when to switch from one role to the expectations of another (Hare, 2003). Overall, Hare's (2003) research on organizational roles labeled this process of switching

roles as a drama-based performance, similar to an actor playing several different characters in a play.

Leaders who switched roles often developed their initial roles from daily contact with others in the workplace (Griffen, 2002). These workplace encounters allowed individuals' roles to emerge from interdependency on others in the environment. These individuals used their coworker interactions to characterize how they should behave and what their contextual role. As the roles switched, the negotiation of the leaders' behaviors and communication changed (2002). Organizations benefited from a leader's ability to switch roles properly when dealing with others (Sheard & Kakabadse, 2005). Benefits included better relationships, productivity, and decision-making skills. Hospital chaplains, considered official "leaders" in their organization, contributed to the spiritual leadership that takes place (Wittenberg-Lyles, et al., 2008).

The "two-hat" syndrome referred to public safety officers who held multiple positions in safety. These positions, although related to each other, had different expectations and called for a new set of people with whom to interact, such as EMTs or security officers (Trainor, & Barsky, 2011). The authors at the Disaster Research Center noted that these professionals encountered moments where they dealt with conflict or ambiguity due to their multiple role expectations.

Organizational Liaisons and Networks

Research in network analysis looked at the different links between individuals, departments, and units in organizational settings (Luke & Harris, 2007). Freeman (2004) discussed the paradigm of network analysis and its four features: Network analysis 1) structurally focused on links, 2) utilized empirical data, 3) made frequent use of mathematical computation models, and 4) utilized detailed graphical representations (2004). Within this field, the term liaison described those who were highly connected. Typically represented in graphic or

model form, liaison representation placed the person in the center of a larger group of individuals or departments. While a fruitful conception of liaison, graphical representations only showed who connected to whom without addressing the actual communication behaviors these people exhibited.

Ennett and Bauman (1993) conducted a popular study of social network analysis who looked at the likelihood of smoking in adolescents who were considered isolates (low connection in the network), clique members (a group members in a network), and liaisons (highly connected individuals in the network). Their initial results found that isolates in the network were more likely to consider smoking, but later results showed members of cliques or liaisons were more likely to smoke among middle-school individuals. The authors noted that group members and liaisons had more connections. Absent from this study were actual messages and interaction behaviors that should be at the heart of communication research.

Previous network analysis research places liaisons in a central position on a pictorial representation of organizational connections. Similar to previous research, this study also defines liaisons as connecting to many organizational members. This study deviates from those previous research studies by moving the focus from where people exist on a pictorial representation to the actual communicative interactions that connect organizational members. While network analysis provides visual structuring, through the links between various entities, this study highlights the communication behaviors of organizational members who have a multi-dimensional role that maximizes the number of people with whom they communicate.

CHAPTER THREE: METHODS

To explore the research question, this study used an interview method for data collection. This qualitative research method included a purposive sample of participants. Following Institutional Review Board approval, procedures involved online recruitment and advertising. Hospital chaplains participating in the interview answered a series of open-ended questions in a semi-structured format. Initial thematic codes emerged and trained research assistants verified the coding scheme before the researcher combined the codes into larger categories designed to answer the research question.

Research Perspective

Symbolic Interaction, the study of “how communication shapes individual identities, making both individuality and social community possible” (Craig & Muller, 2007, p. 366), guides the design and execution of this study. This theoretical tradition carries several propositions (Lindlof & Taylor, 2011). First, meaning is a product of interactional processes within society. Dyadic, small group, and organizational members create shared meaning as part of their daily societal and organizational functioning. Second, reality is not objective, but there are multiple realities all capable of change. In this way, reality, subjectively observed and captured through research, highlights the phenomenon within a specific context of time and space. Finally, researchers welcome the presence of both self and society, creating open lines of communication as necessary for a democracy (Lindlof & Taylor, 2011).

Hospital chaplains, part of a larger working community of medical professionals, possess multiple identities and roles within the organizational setting. Through their communicative interactions with others, they create, maintain, and recreate their identities and roles. A symbolic

interactionism (SI) approach to this study allows for context and symbols to reflect hospital chaplains' lived experiences using their words. By collecting chaplains' accounts, others may better understand how they define their roles and communicate their identity at work.

Consequently, this study uses a qualitative approach to gain a *clearer* understanding of how the hospital chaplain communicates to negotiate the multiple *meanings* of the role and accommodate others.

Sample

Hospital chaplains interviewed for this study specifically work with a hospital or medical organization. The goal was to examine general communication behaviors before further exploring specific individual and organizational characteristics that may contribute to differences across chaplains. Thus, length of employment, number of hours per week worked, sex, age, denomination, and specialized training were not part of the purposive criteria. Any publicly available phone and email information as well as publicly accessible social media pages generated the initial mechanisms for contacting potential interviewees. The researcher asked each hospital chaplain to pass the recruiting statement on to others who might be interested as part of a snowball technique.

Chaplains as Participants

Sixteen hospital chaplains participated in semi-structured qualitative interviews (Denzin & Lincoln, 2017; Longhurst, 2009) for this research study. There were 3 females and 13 males. Out of the participants, 11 identified as Caucasian, 2 were multiracial, 2 were African-American, and 1 was Latino. Ages ranged from 28 to 71 with chaplain experience ranging from 3 years to 34 years. Six chaplains identified as Catholic, five as Baptist, two as Episcopal, two as

Methodist, and one as United Church of God. All participants volunteered to be a part of the research study and received no compensation for their time.

Out of the 16 chaplains, 10 were part of the Association for Professional Chaplains (APC). This organization is a national association for chaplains in different fields, including military, universities, and correctional facilities. Seven of the nine APC chaplains entered the study because of a posting on the APC's public Facebook group page. Although chaplains were all in the medical field, locations across the United States included, Delaware, Florida, Indiana, Louisiana, Kentucky, Missouri, North Carolina, Oklahoma, and Tennessee. Using pseudonyms, chaplains provide a basic overview of their roles to help situate the upcoming findings. Consistent demographic information for each appears in Table 1.

Betty is a staff chaplain at a large southern medical center, where she works directly with hospice care patients and staff. She is part of a large medical team and a full pastoral care staff. Betty has been in her position for over 23 years and is knowledgeable in several areas of hospital care. Betty has experienced many instances of death and grief while dealing with patients and their family members.

Calan is a staff chaplain at a large southeastern medical center, where he works directly with members of the community on specific projects in addition to being part of the hospital's heart and lung care unit. Calan has worked with his hospital for over 14 years and has a large network of people from whom to pull. Although his career as a hospital chaplain is young, Calan is actually in his 50s as he spent many years serving as a Baptist clergyman.

Jared is the director of the pastoral care department at a large southeastern medical center, where he is a part of not only the chaplain staff but also the administration team. Jared has been in his role for 26 years and continues to enjoy his position. As a staple among

Table 1
Participant Demographic Table

Name	Age	Sex	Ethnicity	Years of Experience
Betty	54	Female	White	25
Calan	56	Male	Black	15
Jared	61	Male	White	26
Todd	44	Male	White	24
Jordan	48	Male	White	22
Topher	51	Male	White	27
Frank		Male	White	20
Heather	32	Female	Multiracial	3
Barry	46	Male	Latino	14
Sheryl	34	Female	White	6
Stan	71	Male	White	34
Richard	45	Male	Black	24
Nathan	39	Male	Multiracial	19
Spencer	48	Male	White	22
Edward	52	Male	Black	21
Tricia	34	Female	White	5

community leaders of faith, he continues to grow his network of contacts. Although he has worked in several areas of the hospital, Jared's splits his time between the Emergency Room (ER) and hospice care.

Todd is a member of the chaplain staff at a large southern medical center, where he works with a fully staffed chaplain team. Todd has been a hospital chaplain for over 23 years and mainly works with the ER and Trauma units. Todd focuses on understanding how to build and maintain good relationships with his co-workers and works with the medical department's education center.

Jordan is a member of a fully staffed chaplain team at a mid-sized medical center in the Midwest. Although housed in the cardiology department, he also floats across departments as he works with others on his team. Jordan has been a chaplain for over 20 years and has been at his current organization for 11. Jordan's chaplain team is unusually large as many of them are full-time employees, with part-time employees, and volunteers (interns and community pastors).

Topher is the head of the chaplain staff at a large medical center in the Midwest, where he works directly with Trauma care and the continuing education department. Similar to Jared, Topher is also a member of the administrative team and often participates in meetings and planning for the organization's future. Topher has been with his organization for 16 years and has been a hospital chaplain for 27 years.

Frank is a member of the full-time chaplain staff at a regional medical center in the south. He has been there for 20 years as a chaplain. Frank splits time between the trauma center and the local cancer center, which is located in another building. His organization, although in a small town, runs a large center as two former hospitals merged and became one large medical center. Since the merger, the hospital hired additional staff members to keep up with demand.

Heather is typically a full-time member of the chaplain staff at a large medical center on the southeast coast; she is currently working only part-time. Heather works mostly nights and fills in for other chaplains when they are not available. Pediatrics and the Neonatal Intensive Care Unit (NICU) are her primary responsibilities. Heather is relatively early in her career as a chaplain; this is only her third year of hospital chaplaincy.

Barry is a full-time chaplain at a large medical center on the New-England coast, where he is a part of a small, three-person chaplain team. He has been with his organization for 8 years, but a hospital chaplain for 14. His responsibilities include service to the external clinic locations as well as locations across the state border. Barry also fills in on floors at the hospital's main location during busy times.

Sheryl is the one-person staff, full-time chaplain, for a large medical network of hospitals. She is currently the only chaplain for her location where her effort are mainly in the trauma unit and the NICU, two of the hospital's largest departments. The bulk of Sheryl's interactions as chaplain have been with adults. She has been a chaplain for six years.

Stan, a retired pastor at just over 70 years old, is a full-time working chaplain with a large medical center in the Midwest. Mainly part of the Intensive Care Unit (ICU), Stan has worked in all hospital departments. He considers his several chaplains as fully staffed, even though there were more on their team in the past.

Richard is a full-time chaplain with a large Midwestern medical center. His primary assignments are with the ER department and medical surgery units. He has been a chaplain for over 22 years and has been with his current organization for 18 years. Richard is one of two chaplains who make up the paid staff. Although the medical center is large, funding only budgets for two hospital chaplains and supplements the other services with community volunteer clergy.

Nathan has been a chaplain with his medical center for over 18 years. He is primarily an ER chaplain at a mid-sized, southern hospital. The four-person staff makes the location fully staffed. Although Nathan is usually working with the ER, he has supported all departments and feels connected to the organization through his experiences.

Spencer is a team leader for his chaplain team and oversees five chaplains at a large southern medical center. In addition to the regular staff, there are student chaplains, volunteers, and part-time/on-call chaplains who contribute to the staff. Spencer has served for over 20 years and the majority of his career has been with his current location. In addition to serving ICU and trauma, Spencer participates in several meetings and department committees to improve organizational functioning.

Edward has over 20 years of chaplain service, 12 of which are with his current organization. He is a full-time chaplain with a specialty in hospice care. Edward is part of a small, three-person chaplain team with an additional two on-call volunteers. Together they serve the departments of a small southern medical center.

Tricia is a full-time chaplain at a medium-sized hospital on the southeastern coast. She and her teammate split their assignments as needed and serve the entire hospital together. They are also involved in helping provide information to patients' families and lead grief trainings.

When available, area clergy help Tricia.

Interview Guide

The interview guide, comprised of a series of open-ended questions and statements, invited chaplains to share their workplace experiences. None of the questions specifically asked about patient interactions as those had the potential to include protected health information. The interview guide also avoided patient interactions as those may create uncomfortable situations

for hospital chaplains trying to determine how much information they could reveal without violating their personal and professional ethical standards. None of the questions or probes asked about health information or sensitive, identifying information about themselves or others in the workplace. Similarly, all names of hospitals, employees, and patients/families presented are pseudonyms to protect participant confidentiality.

Using the interview protocol, chaplains began talking about their experiences in the hospital and medical environment. Although the protocol questions served as a guide, other questions, follow-up questions, and probes served to maintain the conversational flow of the interview and delve deeper into their experiences. The protocol questions addressed five areas, including information seeking/sharing behaviors, role management, expressed value, advantages/challenges, and demographics.

Information seeking/sharing behavior questions assessed the ways in which chaplains send and receive information in their organization. An example question would be “How do you stay informed about decisions being made at your institution?” Role management questions, such as “What considerations do you make when communicating with different co-workers” highlight chaplains’ ability to switch from one role to another. Expressed value dealt with chaplains’ own perceptions of how their organization values, or does not value, their position (e.g., “Explain a time when you felt your position/department was/was not valued by the institution.”). Items such as “Tell me about a time when you feel it is challenging to communicate with co-workers” examine the costs and benefits of being a hospital chaplain. Finally, chaplains labeled their own demographic information concerning age, sex, and race. Each interview concluded with a thank-you to the chaplains for their time and contribution to the study. They once again received

contact information if they were interested in contacting the researcher with any additional questions or concerns.

Procedure

Upon approval from the Institutional Review Board (IRB), invitational phone calls and/or email messages served as the recruitment procedure. Phone calls made use of publicly available hospital pastoral department contact information. A request for participation invitation included information about the research study and the researcher's intentions. The researcher and chaplain negotiated a mutually agreed upon time and place/mediated channel.

After agreeing to an interview, each participant received a statement describing the study's purpose, potential risks and benefits, researcher contact information, and how they and their responses would remain confidential. Chaplains were clear that their participation was voluntary and no compensation for their time existed. Participants could choose to end their participation in the study, even in the middle of the interview, or ask to have their data removed from the analysis after completing the interview. If participants consented and agreed to continue participating, they signed the form and returned it to the researcher for filing. Once filed, an official time for the interview could be set.

To interview participants from around the country, an online call-conferencing device recorded all 13 long-distance contacts. Each participant used an email link to join a private conferencing session at the agreed-upon time. Once at the site, chaplains entered a special code to enter the conference where the researcher greeted and reminded them of their rights as a participant before the recording began. After verbally expressing their willingness to participate, in addition to the written document, the recording began. The remaining three interviews used a face-to-face format. A hand-held digital voice recorder with a micro-SD card stored the

responses. Until transcribed, all participants' voice recordings remained on the original devices as well as files on a password-protected computer. Once transcribed, all voice recordings remained intact until the researcher verified the transcripts and completed the analysis process.

Data and Analysis

To analyze the data, the researcher utilized a grounded theory approach while taking a social constructionist perspective (Charmaz, 2014). After interviewing, the researcher converted each recorded file into electronic text format using word document software and wrote an interview memo to track new thoughts and concepts, providing further insight into the research and grounded theory approach. Once transcribed, the researcher took an active role in reaching an understanding of the data collected. As a result, the researcher “encourages innovation” and “can develop new understandings and novel theoretical interpretations of studied life” (Charmaz, 2008, p. 398). This approach allowed the researcher to recognize his role during the research process and consider the subjective, multiple realities that existed in different interactions with participants. This analysis style was most appropriate because it allowed the participant data to become the starting point for finding patterns. As an inductive approach, the theoretical framework emerged in the analysis process.

Using a selected transcript, the researcher engaged in early analysis for key phrases and words. Side notes served as early concept development. During structural coding, the researcher labeled the initial data (brief notes collected during the interview process). The structural coding of the raw data developed the memo code, which resulted in the following 12 labels: Morning Meetings, Serving Patients' Families, Email/Newsletter, Serving Staff, Interdisciplinary Team Meetings, Natural Interaction, Being Present, On-call Duty, Patient Advocacy, Bridged Reports, Almost Thanks, Implicit Exclusion, Liaison Communication, and Universal Resources.

Throughout the coding method for each interview, commonalities developed. The researcher wrote memos of patterns and themes occurring in the data for later reference. At the end of each interview, constant comparison examined the similarities and differences between codes occurring across interviews.

Next, a second cycle pattern coding method (Saldana, 2009) examined similarly coded data to summarize them further into sub-categories. Two research assistants helped with organization and category development. The 12 thematic areas represented the structural (morning meetings, serving patients' families, serving staff, interdisciplinary team meetings, on-call duty, and universal resource) and communicative aspects (natural interaction, being present, patient advocacy, almost thanks, implicit exclusion, and liaison communication) of the chaplain position. While these divisions were an accurate representation of the data themes, they did not fully represent the lived experiences of these chaplains.

To assist in the data analysis, two coders (research assistants) examined identical transcript copy. First, an initial discussion and training session clarified the process of analysis, practice, and discussion of how to handle the transcripts. Following this session, the coders analyzed the first two transcripts from the data separately and then met again to compare their results. The coding scheme used by the research assistants included a list of categorized behaviors referred to as codes. Each category included a small code definition and guided training for sample sessions. Once they were comfortable with the codes, they used it to record their perceptions of the chaplains' experiences.

To find the assistants' coding patterns, and ensure they were coding with the same confidence, the researcher used sample data to find inter-coder reliability. Each assistant independently coded three participant transcripts. Complete agreement among the coders reached

a level above 90 percent; using these same numbers, the statistical agreement was .89 using Cohen's Kappa. After achieving acceptable inter-coder reliability, the researcher used the coding scheme to complete the analysis. A copy of the final codebook is included as Appendix B.

During the third level, Axial Coding Method (Saldana, 2009), the researcher analyzed results from the first two stages further and discovered how the categories and sub-categories intersected with one another. The researcher triangulated the findings and journal memos to review and check his understandings. Finally, the researcher narrated new emergences, findings, and memo references to determine study implications. A final iteration of abstracting the data yielded a set of three themes that cut across the categories developed previously. These themes, discussed fully in the findings, are role/uncertainty management, building relationships, and paradoxical interactions. In each case, the structural categories help explain why the interactive or communicative categories work the way they do.

The included participants represent the participants recruited for the study to the point of saturation. Saturation is a measurement form debated among scholars in qualitative research (Bowen, 2008; Charmaz, 2006; Strauss & Corbin, 1998). While some scholars see saturation as an extensive measurement over time, others refer to saturation as a subjective goal related to the participant pool (Mason, 2010). This study uses a point of saturation that aligns with the strategy of representing the participants. As a result, the 16 participants included have reached a significant point of representation for hospital chaplains.

Using the interview questions generated and the protocol of questioning, the researcher was able to obtain a point of saturation with this participant size. In other words, the patterns in responses from these participants was clear. During interviews 13 and 14, the researcher began noticing that participants are revealing no new information. Interviews 15 and 16, already

scheduled, take place as planned. At this data collection point, saturation resulted because no new information created a new coding category (Charmaz, 2003). If saturation were based upon the various background, years of experience, hospital size, and denominational affiliation characteristics, then additional interviews would have been necessary to reach saturation within each characteristic. Instead, saturation reflected the communication patterns of hospital chaplains who volunteered to participate in the study. At saturation, recorded interviews produced 254 double-spaced pages with 6,177 lines of typed text (12-point font). Interviews ranged from 18 to 61 minutes, with an average of 34.38 minutes.

CHAPTER FOUR: FINDINGS AND DISCUSSION

Chaplains reported working in different types of hospital environments. While most reported working in large medical centers with educational training, others reported working in smaller hospitals where they had no large chaplain staff and were the primary chaplain contact. These differences were significant; however, findings below were consistent, regardless of hospital or chaplain staff size. The following quote captures the researcher's response in a memo from the end of an October recorded interview.

“These last few months have been very interesting as I sit and listen to each chaplain describe their work experiences. No matter who I speak with, the stories sound similar and unified. When I started this project, I speculated that chaplains were probably doing more than their fair share and not getting recognized for it, but I had no idea this would be a common story across the country. The contribution of a chaplain is invaluable to their organization for the type of service they provide. However, because they are not a revenue-generating department, it's hard for others to see what they bring to the table. In fact, most chaplains have talked about the downsizing of their department or how it's being phased out to an “on-call” position for one. I've learned so much about what they really do and a lot of it is not the expected prayer or scriptural reading. These individuals deal with everyone inside, and outside, of their organization. They have families of their own, that they leave behind, to help mend and manage other families who are hurting. This research has helped bring these people to life. They are not the praying robots that people think they are. It's more than a prayer; in fact, it's a career of organizational ministry.” [October 21st, 2016]

The purpose of this exploratory research study was to explore the roles and communication behaviors of hospital chaplains in their work environment. After conducting a series of preliminary coding, three broad themes revealed a clearer image of the hospital chaplains and their communication behaviors or interactions. To analyze the data, interviews went through a series of coding episodes. The researcher, after achieving inter-coder reliability with trained coders, analyzed each interview separately with a minimum of 12 hours between each coding series. The following sections explain and discuss each of the themes—Role/Uncertainty Management, Building Relationships, and Paradoxical Interactions—that consistently appeared in their lived experiences.

Role Management and Uncertainty

Hospital chaplains serve both internal and external stakeholders, including patients, families, staff, social workers, community members, and congregations. Interacting with so many stakeholders, many of whom the chaplain may meet for the first time on any given day, means that chaplains need to be able to assess the role they need to be playing as well as stay aware of their uncertainty when interacting with a new person or in a new situation. Their ability to manage their different roles and uncertainties reveal both triumphs and setbacks in the chaplains' lived experiences. Intertwined within this theme are stories of the ways they manage their different, and often unexpected, roles create a very unpredictable day at work.

When asked about how he would interact with co-workers and manage their different environments, one chaplain recalled how the staff was able to establish relationships with different co-workers in their department.

“Everybody has assigned areas, and whether it's in the administration building, which is one of my areas, emergency department, ground floor, environmental services, food

services, we make pastoral rounds, informally walk through, check in, people approach us, so it's a ministry of presence as opposed to more scheduled appointment, formal stuff. We do that primarily through rounds of team leaders or nurse managers or department heads, knowing issues that are going on in their department. That can lead to a meeting, or a one-on-one counseling, or whatever, referrals, that sort of thing.

[Spencer, Lines 88-96]

Spencer is explaining how set responsibilities battle against the reality of what happens each day. Although chaplains may have an idea of what needs to be completed, the time needed to finish a “to-do” list varies. They must handle their own work responsibilities when others do not need them. Often, the required amount of time does not exist in a given day because they have to be present in the moment for those who need them. Formal meetings are the one exception where they have dedicated, set-aside time to talk with others about what is happening in the hospital and how to improve operations. While formal meetings are more common when there is a chaplain staff, the idea of being present for others appears in all different types of hospitals.

Uncertainty, typically more pronounced in an emergency, occurs because the department functions in a world of uncertainty about when the next injured or ill person will walk through the door. Yet, Richard provides an interesting perspective that echoes this notion of being present in the moment. He explains the challenges of switching roles when dealing with multiple people in a busy, and sometimes crowded, environment.

“So, Monday night I was called in. Our ER was swamped. They were on diversion; could not take any more patients in. Waiting room full. I actually had a lady in there that was a member of my church, you know, and so I was able to go in and visit with her. They actually admitted her. I was able to take her [inaudible] after they got her in a wheelchair

and push her down to Med-Surge, into her room, which helps the nurses because they were busy. The ER, like I said, was on diversion.

After leaving Med-Surge, coming back in the ER, we kind of direct traffic, telling people in waiting how long they would be before the doctor could come in. They triage everyone as they come in, but sometimes they have to wait after that. Just keeping people in the waiting room advised to progress and when they're going to get to them. Small town. Small hospital. ER sometimes become the doctor's office. If you have like an hour wait, 2 hour wait, that's quite a long time. They try to meet the goals from door to door, you know, in an hour, hour and a half, depending on the severity of the emergency. I just call that "directing traffic." Sometimes people, they need a word of encouragement also so you switch your hat from being a messenger boy back to your chaplain hat for spiritual health and comfort." [Richard, Lines 72-85 & 83-91]

Richard's explanation of directing traffic explains the busyness of any hospital's ER department. Even with a staff of chaplains, chaplains' responsibilities change continuously. Although Richard comes from a staffed pastoral care department, emergencies dictate that everyone must be there and help. There are times when the number of people to share the workload may be low, and in an ER department, there could be multiple incidents of crisis needing immediate response. The environment's pulse helps chaplains determine which part of the traffic light applies at any given moment in time.

Even though a hospital chaplain staff means more people to share the workload, the need to manage one's roles in an uncertain environment does not diminish. One chaplain explains the benefit of having multiple chaplains on a staff because they work together to cover for each other and still provide all needed services.

“[I] was in an administrative meeting discussing some patient satisfaction scores on one of the nursing floors and how pastoral care may impact and help the nurses with their benchmarks and their scores. Got paged out of that meeting to meet with a former nurse whose son was contemplating suicide, and got her referred to the appropriate mental health folk. Then, back from that encounter with that family, to a trauma, and then from that trauma, back to a budget meeting. All that was before lunch. That's the yo-yo part of the administration and I enjoy that. Truth be told, that's another huge benefit of having a team: if I were in a meeting and I could not get out of it, I simply call one of my staff and go, ‘Hey, are you in a position to stop what you're doing and go take care of this family?’ We do a lot of handing off and got an incredible staff that are very competent and skilled, so that makes it nice.” [Spencer, lines 221-235]

Teamwork explains how chaplains can rely upon their colleagues in particularly chaotic times. Not every hospital has the luxury of multiple chaplains; Spencer’s awareness of and gratefulness for his team appeared in the way he spoke about them. Even with a team, his need to manage varying roles “before lunch” indicates how overwhelming the hospital chaplain role may be. Role management and uncertainty increase exponentially for one- or two-person chaplain staffs who must rely on volunteers to handle less critical responsibilities.

Although chaplains perceived a normalcy associated with “switching hats,” one of the chaplains explains the difficulty in prioritizing which emergencies to respond to and the decision-making considerations:

“We had a conversation about this yesterday with one of the folks who's learning this trade. She said, ‘Well I was with a family and they were showing me pictures of their kids, but then I got a page to a trauma. What am I supposed to do?’ We talked about what

is your priority here? If you're the only one in the building and it's a weekend and you're covering the whole house, and something profoundly sacred is happening in this space in this moment of time, and you're getting paged to something else you're going to place value on those two things. You're going to prioritize them. If you stay with the person who's unburdening their soul and needs you in that moment then you know you're going to miss something else. Doesn't that add more value to the conversation that you're choosing to stay. We talked what is priority in hospital ministry. The hospital might want you to do certain things, but what is the sacred that is happening and where should you be, where ought you be? [Todd, lines 235-249]

Todd's response again deals with unknown set of responsibilities chaplains must prioritize. Even though each event, in his mind, is attention worthy, they must rank priorities to address them properly.

Determining priorities occurs in every segment of the hospital environment. Those priorities often shift between patients/families and staff in a crisis. Frank describes the idea of managing different roles by explaining how the ER department works along with his responsibilities during times of intense situations.

“Oftentimes, if we're working with, say a traumatic situation in the ER, a major accident or if there's an instance that's been on the news, perhaps an instance of child abuse or domestic violence or shooting or something like that, that gets a lot of publicity and press ... Our primary focus at the moment is usually patients and families but at the same time that you're doing that you also have your finger on the pulse of the staff, as it were. You try as best you can to provide extra support. Oftentimes the support that we would give the staff would be as an after-action report. We often do critical instance stress

management or stress debriefing things with our staffs if there's a particularly stressful incident. There was one not long ago, a young person came in as a suicide and folks who worked with that. I don't know that it's quite as much as switching hats, it's just all part of one process. You normally would ... You keep your finger on the pulse of the staff while it's going on, but most of the time you have time to help staff process after the immediate crisis, as it were. That's fairly common for us. It's not that it would be something that would really stand out. That may happen several times a month for us.” [Frank, Lines 128-141]

Frank refers to managing staff incidents, morale, and emotions as the “pulse” of the staff. A pulse can signal crisis or normalcy depending on its level. A pulse can go from low to high, without warning, and chaplains must be alert to respond properly. In this case, Frank attempts to handle two priorities simultaneously even though his interactions with the family and staff may be iterative with him flowing between groups.

As a closing example, Sheryl provides the role management perspective of someone who works as a staff of one. She mentions not only the challenge of managing roles, but also the complexity of one incident that calls for several steps.

“You can be minding your own business and you get a call for a code that's coming in. Sort of the system rule for spiritual care was not to round in the ER unless you were called there, but when I came to the community hospital I would round in there. At first people would say, "Who died," and I'd be like, "Nobody, I'm just coming to say hi." Now it changed to, again, building relationships. It changed to them calling me. We're often in that room together before the patient comes, and then when the patient comes I usually get the family information. I do step in and hold the patient's hand. I have stepped in and

put my hand on the baby when they're coding. I've stood with family in the code. I've stepped up and whispered to a doctor, "Let me get the parents out of here before you call it. Then when it's over I have to go into administrative mode and make notifications to the coroner, and do paperwork, and if the coroner's responding to the hospital then I have to make sure security's there. I work really closely with the nurse administrator of the day, so we're sure we're on the same pages." [Sheryl, Lines 150-165]

Regardless of whether the chaplain works alone or in a group, managing roles and potential uncertainties is part of the territory. Her rainbow of hats illustrates the juggling act experienced by all of the chaplains interviewed.

Organizational roles represent the joint expectations of the worker and the workplace (Schuler, Aldag, & Brief, 1977). In other words, the position (e.g., hospital chaplain) individuals have within the workplace environment represents who they are in service to their organization. As a result, roles become the bond between an organization and the working individual, so that workers are able to associate themselves with the organization professionally (Schuler, Aldag, & Brief, 1977). Although roles help connect workers to organizations, they can also become a barrier to an organization's effectiveness when the role is unclear (Kahn, et al., 1964). In a similar sense, it may be just as complicated for those with multiple roles if those expectations compete. For example, hospital chaplains serve not only patients but also the staff. Each group's expectations may be contradictory with respect to topics such as death, safety, and other life decisions. Different sub-groups have different goals and motivations when interacting with chaplains.

These responses, collectively, explain a common narrative of the day-to-day interactions for chaplains in their work environments. The metaphors of directing traffic (Richard) and taking

a pulse (Frank) illustrate the unpredictable roads on which chaplains work. Their workdays include speed changes, hairpin turns, detours for construction, and steep inclines/declines. Because of these experiences, chaplains see change as a workplace norm for which they must be prepared. To deal with the situations that await them, they must operate with an awareness of constant uncertainty.

While managing roles and uncertainties is typically an individual responsibility, hospital chaplains encounter more opportunities to engage in these behaviors because of their liaison role. Because they are highly connected, chaplains confront a multitude of happenstance and impromptu situations. Some are going from one situation to the next; others are going from one person or department to the next without breaks. These back-to-back events happen without warning or announcement; chaplains must be able to change hats quickly and anticipate how to handle each new situation. On any given day, they face a variety of stakeholders and must communicate effectively with each one. Because switching between roles and changing their communication behaviors is so ingrained in the position, many did not even talk about it when asked to describe their responsibilities at work. In this way, they are unique contributors to the organization's functioning and success.

When discussing the hospital chaplain's role functioning, role clarity is essential to the discussion. Role clarity can include the amount of information received about the position and/or the subjective feeling of having enough information about the position (Lyons, 1971). For hospital chaplains, their roles change consistently while they also manage new information. As a result, participants noted how understanding their chaplain role becomes a challenge. While some similarities transfer across situations, each person who enters the hospital environment brings a unique set of experiences and reasons for being there. Hospital chaplains must

assimilate the new information, assess it in light of their previous experience with similar individuals/situations, and develop an effective communication plan quickly.

Role ambiguity and role conflict dominate the connection between structural characteristics of an individual's organizational position and personal, behavioral, and affective consequences (Kahn, Wolfe, Quinn, Snoek, & Rosenthal, 1964). "The person must be able to anticipate with fair accuracy the consequences of his [or her] own actions.... He [or she] needs to have useable knowledge about means-ends connections in situations where he [or she] can produce or withhold the means" (p. 72). Ambiguity refers to the individual's behavioral outcomes unpredictability. Hospital chaplains discuss their roles as mirroring the characteristics associated with greater role ambiguity and conflict: (1) cross boundaries, (2) produce innovative solutions to exceptional problems, and (3) be responsible for the work of others within the organization (Kahn, et al., 1964). Consequences of experiencing role ambiguity include increased tension, job dissatisfaction, a sense of futility, and lower self-confidence (Kahn, et al., 1964). In addition to the unpredictability of behavioral outcomes, Rizzo, House, and Lirtzman added a second component to the definition: "[a lack of] the existence or clarity of behavioral requirements, often in terms of inputs from the environment which would serve to guide behavior, and provide knowledge that the behavior is appropriate" (1970, pp. 155-156). Similarly, previous research in organizations correlates low role ambiguity with reduced turnover and increased loyalty and identity (Lyons, 1971). Hospital chaplains' narratives indicated a low-level need for clarity and high tolerance for ambiguity to engage in role switching; thus, they do not feel the negative outcomes as powerfully as those who have a greater need for clarity and lower desire for ambiguity.

More recently, Eisenberg (1984) describes role ambiguity as effective to the functioning of organizations. He discussed the idea of organizations having a role that is ambiguous being a necessary norm to the organizational culture. This is attributed to some roles (i.e. hospital chaplains), which have multiple expectations, competing goals or priorities, and call for strategies that are ambiguous but still productive. He referred to this unique instance as strategic ambiguity, which refers to an organization's intention to be unclear in protocol with their communicative responses. Whether hospitals are aware of the positive ways in which the role ambiguity for hospital chaplains is working to their benefit remains an unanswered question.

Relationship Building

A second theme that emerged from the data was building and maintaining relationships. The participants' stories that communication becomes a conduit for successful encounters and managing people experiencing crisis. The participants' responses support the idea that communication helps constitute the environment chaplains may need to create at any point in time. Since many interactions that happen in a day vary, chaplain communication in each interaction is imperative. This study focuses on how communication behaviors manifest in this environment. The relational communication patterns speak to the chaplains' ability to communicate effectively with different organizational sub-groups. As a result, some instances may include moments when they need to reach shared meaning with a non-medical coworker, patient, or medical professional. Therefore, language usage helps bring them closer to individuals as they try to speak to those people on their level.

Sheryl recollects not only being considerate of her own communication, but also of a coworker's communication behavior. She explains her prior interactions with a doctor when having to deliver difficult news.

“I’m very mindful of my tone of voice. Because I think one of my gifts is being able to utilize a soothing tone, and being aware of volume, and just saying, “I’m so sorry,” and sitting with patients and families in the silence. It has taken some time to get the doctor in the ER, some of them are new doctors, and we kind of have a new ritual before we go and talk to the families. They like for me to go with them and I’ll remind them, “Do you want to get your white coat,” and some of them are like, “Oh yeah.” One doctor and I have kind of a standing joke. He hates doing death notifications and he’s horrible at it. He said, “I’m going to go to the bathroom.” I said, “To throw up?” He said, “Exactly.” I said, “I’ll be here waiting for you.” I kind of normalize his anxiety, and wait for him, and the last time we were together on one I said, ‘Take your time.’ Because he tends to jump right in, “I’m sorry, he’s dead.” I said, ‘Remember, take your time,’ and I said, ‘Take a deep breath before you start.’ He said, ‘Okay.’ We got in there and he did it again. ‘I’m sorry, she’s dead.’ The family was not prepped for that, they were not ready at all, and they totally lost it. It was interesting, he came back later and said, ‘Do you want to talk about that? Do you have any pointers for how I can do that?’ We had a really good conversation. He’s like, ‘I’ve always been taught not to belabor the point.’ I said, ‘Giving them three sentences is not belaboring the point.’ I said, ‘You’re very good about using the D-word, but give them a little bit of prep.’ That was a good conversation. This kind of not shaming him about that, or going to his supervisor, or any of those things, enabled us to have a really good conversation about it...and acknowledge that it is a difficult thing to do.” [Sheryl, lines 206-229]

Although delivering the news is the task, both Sheryl and the doctor are able to work together to create a better working relationship. As Sheryl pointed out, helping the doctor properly give

news without upsetting the family more is the task-related communication. At this point, Sheryl describes the ability to bring doctors closer to the patients with whom they interact by improving their communicative expressions. Although this is not a set role task, Sheryl uses her unique position to have this sensitive conversation with the doctor.

Heather echoes Sheryl's sentiments regarding the critical nature of the way doctors interact with and deliver news to patients. In a single example, she explains all that is involved with the explicit and implicit relational responsibilities of a chaplain as well as the numerous relationships that develop in a single healthcare case. She captures an instance of being helpful because of her role and its utility.

“Other times just ministering to people in situations where they feel hopeless. Like sitting down with people and saying, ‘Okay, you're facing this situation. How do you feel about that?’ Walking them through times where they've never been before. I've been with families in the ER whose love one coded, and they brought her back, and they coded, and brought her back, and they were moving her up to ICU. I walked them down the hallway, I don't even know if they knew what they were doing, and just sat with them in the moments, in the last minutes of their loved one's life. I was with them, and then I was talking with the doctor to help him communicate what the family needed to hear at the time, because they were blaming themselves. I was the go between, between the doctors, and the nurses, and the family. In the ICU unit, in that end of life situation, I often try to be a communicator, and interpret some of the things that the doctors will tell the family when the family ... When he or she leaves the room, and the family doesn't understand what the doctor has just said. I interpret, and help them understand, the severity of the situation, or not. Sometimes I'm a resource person. I help find resources, or help connect

the family, or the patient, with a social worker, or point them in a direction where they can find resources. I don't do that a lot as much as I am just ... I'm kind of an intermediary sometimes. I also do a lot of ministry to the spiritual side of patients. Depending on what their faith connection is, I try to meet them where they are. I don't try to push my beliefs, although, that's the court, who I am. I try and meet them where they are, and try to give them some kind of spiritual help. To sum all of that up, I often tell people I'm part of their medical team, or part of their care team at Ovation, because Ovation takes a holistic approach, body, soul, and spirit, and I'm the spiritual side of that. I'm the spiritual ... I don't call myself a doctor, but I'm the spiritual side of that. I'm part of their care team. That often gets me in the door when some people might put up a red flag. 'No, I don't want a chaplain here,' or whatever." [Heather, lines 90-119]

Here, Heather explains how she builds and maintains relationships, even with individuals who may not understand or want "spiritual" care. While others in the hospital environment may have to impose the specifics of their procedure or process on the patient, Heather uses these moments to reach shared meaning with patients. She recognizes that everyone in the hospital may not necessarily want to receive spiritual accommodation; however, there are still opportunities to connect. Chaplains interact with those who do and do not have denominational affiliation and still contribute to patient satisfaction. Heather provides the first indication of hospital chaplains fulfilling the traditional role of liaison where they take information from one organizational member (i.e., doctors or nurses) to another organizational member (e.g., patients or families).

Chaplains, when dealing with patients, often deal with a patient's family members or close friends. These individuals are the ones who also desire information about the patient and may have a varied set of emotions depending on the situation. As a result, hospital chaplains

have frequent interactions with a patient's love ones. Some of the chaplains recall their experiences with these individuals.

“I had a conversation with somebody and they were saying that, “I just can't do that...I couldn't have that on my conscience.” and so on and so forth. And so I said....and this was a woman who was I think 80 and she had been in good health then had a massive stroke...and it just was not going to have a good outcome. But her son says, “I just...I can't take her off the vent. I couldn't live with myself.” then I said, “well what would your mother want?” and he said, “oh well I know what she'd want. She would not want to be kept alive and she would not want to live like this. She would not.” so I said “hmmmm, you know what she would want. So ummm, could it be possible that if you allow them to take her off the vent and die a natural death, you might be giving her the gift of honoring her decision.” “well, I don't know....I just don't think I could do that.” “well it's something to think about” and I use this example a lot because my mother is almost 93 and she's been telling me for almost 15 years at least, “I do not want to be resuscitated! I don't want this and you better not let them put on a ventila-...and you know blah blah blah.” And I get that and I will not do it...now, I'm not saying that it will be easy, but I'm saying that I've had it drilled in my head long enough that I really do understand...it's her decision. And so as her daughter, who loves her, I have to honor her decision. And it really is a gift, to have somebody that you know who will do that for you. And some folks are able to see that, in time...and talk about it as a family...and some aren't you know and so ummm. But I think, here again, we are just there to be supportive in, you know, in whatever way we can.” [Betty, Lines 148-166]

Betty explains the importance of helping patients or families become aware of their decisions and the implications, including life and death. Even when the topic is sensitive, the chaplain serves as a sounding board that is only possible once a relationship forms. Similarly, part of supporting others involves playing the liaison role to connect the patient and family members. In the example above, Betty uses her personal experience to remind the son what he has likely heard from his mother multiple times. Even though information does not transfer back to the patient, the chaplain is still the conduit through which the patient speaks to the son.

In addition to serving as liaisons between people, hospital chaplains find themselves building relationships with patient families by linking them to a higher spiritual being. Often, they engage with families without speaking a word. Chaplain Calan explains the tough parts of grieving with a family.

“the patient’s families are almost always crying. Ummm, sad. Ummm, you know they always, always sense the helplessness because, you know, no matter how much we know or what we’ve done in the past when it comes to this point in our lives there’s nothing we can do. So, it’s always a sense of kind of heaviness in the room and I can’t change that but what I do want to do and try to do is give them some support and pray with them. Always ask ummm, to come, to get around the patients’ bed and join hands or put your hands on the patient and I’ll put my hand on the patient sometimes. Kind of a heaviness a sadness in the room, which is normal.” [Calan, Lines 91-98]

In these tough moments, Calan shows how chaplains provide excellent spiritual care. Their ministry of chaplaincy allows them to engage in spiritual support. Since they excel in these moments, chaplains’ support creates bonds that may never be forgotten.

Within this theme, Jared sums up the experience of dealing with patients and families by explaining what these individuals appreciate about seeing the chaplains.

“first you have to determine if they really are family and how they’re related or connected to the patient. Umm, and so that’s one key... is to build a relationship, letting them know that we’re trustworthy, we’re here for them. I had a lady the other day tell me we were the only people in the hospital that came to visit her without wanting anything from her (i.e. we weren’t going to stick her, we weren’t going to draw blood, we weren’t going to make her take medicine) we were just there to see how she was doing as a person. She said, “I’m not just a hip”, she was having hip replacement, “I’m not just a hip with yall, I’m a person.” [Jared, Lines 95-101]

Chaplains not only deal with patients and patients’ family members, but they also serve those within their own organization. This allows for frequent interactions with their co-workers and their coworkers’ family members. Tricia recalls a recent encounter with a member of the hospital’s maintenance staff.

“Last week I had one of our guys from maintenance who I talk to fairly regularly, I'd say once every two months. I'm checking in with him about his personal life, basically and his wife's parents have died in the last couple years, and I supported him through that. They don't have any children, so their dogs are their kids. Last week one of his dogs, his first dog that he and his wife got together, died. That was really hard for him. He told me when I ran into him in the hall and then he later came by my office and brought me pictures, and talked for probably about a half hour about some of his grief and memories of that dog and that loss. That was just last week.” [Tricia, Lines 98-106]

Tricia goes on to explain another incident with a distressed coworker. She explains what is occurring in their lives and how she has been there for them.

“there was a staff member who was in crisis and that staff member's co-workers were really worried about that person and affected by his crisis. Talked with them to offer support through that. Another example would be, one of my nurses who had a lot of trouble getting pregnant had a couple failed rounds of IVF [*in vitro* fertilization], and were about to use their last frozen embryo. Their last attempt at IVF, it was going to be their last chance. She asked for me to do a blessing for her on the day before her procedure and pray for her around that and I did that. She's having twins in a couple months, that's exciting. We really do get involved with our personal lives and they, thankfully, trust us enough to invite us into that and utilize us. We do that. I've done weddings, not many, but a few weddings for staff folks. That was outside my facility, that was for [our] organ procurement [department]. Two of our folks in our organ procurement organization, actually.” [Tricia, Lines 108-122]

Tricia recognizes the importance of building relationships with all organizational members. By knowing individual staff members, Tricia enhances her relationship when she talks to them on their terms and about topics that are important to them rather than just work or generic topics. In this situation, Tricia forgoes the formal chaplain role that accompanies an “appointment” to vent about hope, grief, or pain. Instead, the two staff members come to Tricia because she has built a level of trust that allows them to engage in self-disclosure about a significant life event. These positive, supportive experiences reveal the multi-faceted nature of workplace relationships.

Although grief and spiritual care can be a common occurrence, other events may include simple conversation that allow the chaplains to connect with their co-workers through distracting

conversations. In other words, they are able to have conversations with their co-workers about non-task-related topics and allow an escape from the work environment. Chaplain Todd explains:

“This morning I spent about ten minutes discussing Tom Selleck, and his fascinating career as an actor with a group of millennials around the nurse’s desk. I knew exactly what we were doing. We were taking a break from the chaos that had been 30 minutes earlier. For them to talk to me about how hot Tom Selleck is, and for me as a pastor standing there taking this energy with them this very fascinating conversation for me, meant that I’m real. I’m not a pastor or chaplain that can’t be touched or felt. I can say, ‘I can’t believe he starred on *Friends*, because that just didn’t seem right.’ For these folks to enjoy a conversation like this with their pastor, and then turn around and be engaged with a family who’s having the worst day of their life that solidifies my role. It wasn’t a theological discussion on Galatians. It was a discussion about Tom Selleck, and we connected in a way that I feel like the role of chaplain in the hospital is. You’re a chaplain in a hospital. It’s not like we just get dressed up and come see you one day a week. This is where we let our hair down. We talk about the nitty gritty. Quite often, you turn around and a patient’s naked. There’s always sexuality in conversations. There’s all of this real-world stuff, and a chaplain’s right there in the middle of it.” [Todd, lines 147-165]

Todd brilliantly explains how important that moment was to maintaining positive relationships with his co-workers. After experiencing a crisis, he could have left the floor and gone to another part of the hospital to continue his responsibilities. However, he decides to stick around and chat with the nurses about the Tom Selleck’s varied career as a celebrity. He does not have to participate in the conversation; he could have even just listened without saying a word. The fact

that he stays and participates in the conversation to strengthen the ties that he already has with the nursing staff before this moment. The staff experience both grief and social relief with him, which strengthens their bond. These moments represent the indirect ways people build and maintain relationships.

Larry summarizes the importance of creating connections while working together. He talks about the closeness he has with those in his department and in other departments as well.

“I always look forward to being with my colleagues, the chaplains at the hospital. That's where most of them are. I always look forward to those times because the camaraderie is just special. I also look forward to my interactions with the, for instance the nurses in the infusion center because they're very open to me and to what I do and supportive. We have fun. Of course it's not as somber and serious a place as you might think it is. Of course, people are there, most of the people there ... they're living one day at a time and they're positive, not always, but sometimes.” [Larry, Lines 176-184]

The relationships formed, through this collection of responses, vary in length and connection, but share a common thread. Chaplains attempt to develop a personal bond with each person. Whether patient, coworker, medical professional, or family member, others credit the chaplain with enough trust to build relationships. This advantage, afforded to the chaplain, is not always available to others in the hospital environment (Lyndes, Fitchett, Thomason, Berlinger, & Jacobs, 2008). First, hospital chaplains have entrée to all areas of the hospital, which provides them with the means to develop these workplace relationships across all hospital departments. Second, people perceive chaplains as possessing the ability to “stop and talk” as part of their daily responsibilities; effective listening skills enhance these informal conversations.

Chaplain Todd's explanation of simply talking with the staff about a topic of pop culture (Tom Selleck) becomes a shining example of building relationships in the smallest moments. Even though they are at work, these individuals connect as peers without task-related topics. Their conversations allow for an implied investment into the lives of those with whom they interact. Staff members remember those moments when they are working on a task and feel connected to that person due to the interpersonal bond created during the interaction. Even during moments when the conversation is purely social, a chaplain's ability to connect allows mutually beneficial bonds to form.

Chaplains, as part of their job responsibilities, make the "rounds" on patients. They regularly check on patients and inquire about their needs. Although the chaplain offers spiritual care to those in the hospital, investing in individuals builds and maintains interpersonal relationships. Language choices allow hospital chaplains to create convergence and minimize the distance between themselves and others they encounter each day. They achieve convergence by engaging in accommodation (Giles, Coupland, & Coupland, 1991) and person-centered communication (Applegate, 1980).

Through accommodation, people work to reduce interpersonal differences and diminish uncertainties about the other person (Giles, 2008). Actors' language use and behaviors change as they negotiate meaning in communication (Ayoko et al., 2002). When individuals accommodate another person, likeability and competence perceptions generally increase (Giles, 2008). The similarity attraction paradigm explains people's attraction toward others who are like themselves; people naturally alter their communicative behavior to be similar to the person with whom they are speaking to increase likeability (Ayoko et al., 2002). People converge by adopting the other person's speaking style or body language. "Upward convergence" includes

using more complicated words than usual to appear more intelligent, and “downward convergence” includes using simpler words to appear less educated or more common with someone who may not understand difficult terminology (Giles, 2008). Being able to know which direction to converge, however, requires “interpretive competence” to determine what the other person’s level of comprehension is about a specific topic. People converge more toward those perceived as being higher in social power and whose interactions are more socially rewarding. Interestingly, hospital chaplains, according to their own words, engage in convergence without considering social power or rewards.

While people commonly desire accommodation subconsciously or unconsciously, CAT posits that sometimes people purposely do the opposite (Giles, 2008). Non-accommodation, or divergence, involves emphasizing differences in verbal and nonverbal communicative actions. Because liking and approval are not the goal, non-accommodativeness occurs when people engage in “speech maintenance,” where the speaker upholds the same type of communication no matter with whom they are speaking. A person could also be underaccommodative, where they simply do not make an effort to adapt to the other’s needs. Although they are usually attempting to accommodate their co-workers or patients, hospital chaplains sometimes deem it necessary to avoid intentionally finding common ground.

Chaplain Edward explains the idea of non-accommodation or under accommodating when in times of stress or with feelings of being overwhelmed. He talks about the opportunity missed due to a lack of time and pressure to get things done.

"Situations would come up usually because of stress, either physical, emotional, mental, or time constraints. Either stress in me or another team member when either I felt overloaded with things and therefore didn't take the time to calmly communicate with

other team members. Or they might be under time or emotional or physical stress to the point that they didn't have time or didn't seem to take time to communicate with me or let me communicate with them." [Edward, Lines 330-336]

In moments of stress or high emotion, chaplains, or their coworkers, are not able to focus on reaching shared meaning. Since they are distracted with other constraints, it becomes difficult to focus on accommodation.

Chaplain Heather sees non-accommodation as an issue due to a number of differences. She refers to several non-accommodative possibilities attributable to non-accommodation.

"We're all from a different place, I guess, backgrounds, and heritage, we're all from a different place, and communication gets hard when we're not open minded, we don't understand everybody's thoughts, we're narrow minded, and that's when it's hard to communicate with each other. It's also hard to communicate with each other when, for me, I'm not there every day. I'm out of the loop a lot." [Heather, Lines 336-341]

Unlike Edward, Heather describes more task-related issues where an individual may under-accommodate, or not accommodate due to lack of consideration for the other person's knowledge. She also refers to the times when co-workers can be narrow minded, or forgetful that differences exist and everyone may not always be on the same page.

Through non-accommodation, chaplains may also emphasize a point when advocating for patients' wants and needs, especially when talking with medical professionals on behalf of the patient. Similarly, a chaplain may discuss information about the patient using medical terminology, or slang, to bypass the patient's understanding. In other words, creating, maintaining, and dissolving an in-group/out-group atmosphere allows chaplains to communicate strategically based upon the situational demands. Although making accommodation and non-

accommodation decisions may create tension, the primary tensions hospital workers face result from the paradoxes they face at work.

Hospital Chaplaincy as a Paradox

In reflection, I look at the role of the hospital chaplain and I see the tensions and competing goals of the position developing into a paradox of hospital chaplaincy. Chaplains in the hospital environment are a necessary organizational piece, but often viewed as insignificant to the hospital's operation. They offer different perspectives on health, but others perceive them as lacking medical experience. Chaplains rarely "earn" credit for non-spiritual organizational tasks they complete and often find themselves being called upon in times of need. These instances are normal tensions within the hospital chaplain role. Chaplains explain the issues that contribute to the paradoxical nature of their position: being a non-revenue-generating department, returning to work outside of the regular shift, or recognition by others on the job. Chaplains must handle these job-related tensions. How they respond to these tensions differs, but each of them approaches issues with sensitivity and caution.

Chaplain Todd attempts to explain this idea. In his case, he deals with an issue of his position's perceived value while attempting to work with a coworker in his department. He explains his feelings of exclusion and the ability to fight for legitimacy.

"I am the chaplain for the emergency department. The emergency department manager does not use me at all. She's new here. Well, not even new. She's been here a year, maybe a year and a half, and I've tried my best to get in on what's going on. She's not great at people skills. She stays in her office all the time making decisions, and allows her team managers to manage out on the floor. I've mentioned this in round-about ways. Finally, it was pointed out by her senior-vice-president that she is hemorrhaging staff members out

the backdoor, and all she's doing is just hiring new ones every orientation. She needed to figure out a way to get a handle on that. That led me then into her office to say, "I know some things about millennials and these are the folks that you're losing, so let's have a conversation." She's given me the opportunity to put together a focus group of millennials in her department and try to figure out what's going on, so that she can know. Yet she doesn't want to be involved in that. She wants me to do it. You try your best to get into people's face and say, 'Hey I'm here. I've got all this expertise. I'm a very smart guy and I see exactly what's going on in your department. Use me and my knowledge to help yourself,' and then they might know." [Todd, Lines 349-367]

In this case, Todd possesses both spiritual and organizational knowledge to contribute to the ER department; yet, he finds himself underutilized. The tension magnifies when the manager decides he should complete a task, conducting a focus group, not even tangentially related to his chaplain role. Although the chaplain is aware of his ability, he must directly express that to his coworker. Even in his area of expertise regarding spiritual care, he perceives the manager as requiring him to prove he is a credible source and departmental contributor.

When people perceive someone or a group of people in an organization as not credible, they often lack a voice in the organization's functioning. Barry wonders about whether others hear him in the organization.

"One thing to say would be, for example, there are a lot of meetings, a lot of hurdles that we do, and I'm not sure if our function is totally represented equally in every single dimension. Now we say we want to do that, you know? That's one instance where I feel like, okay, wait a minute. Where is *our* voice? Somewhere, you know? To be honest with you, that's the only time I feel like we have to go upstream to carve out a space and a

voice. It's not that they don't value, it's just ... The primary service we provide is medical care. We're a small part of that, definitely a valued part, but it's sometimes we lack a voice.” [Barry, lines 251-260]

Barry’s response reveals that chaplains, who are visible, may also find themselves ignored at the same time. Medical care does not necessarily have to include spiritual care, even though previous research finds a positive relationship between the two (George, et al., 2000). As a result, Barry talks about times when co-workers forget that chaplains have a voice and can contribute to the organization.

While Barry’s coworkers express little appreciation for the chaplains’ efforts, Frank describes the recognition gap occurs at a higher organizational level. The hospital administration views the chaplains as detached from the hospital while the nurses and other medical personnel provide sentiments of value.

“From an administrative level, here we call [it] the mezzanine because the administrative offices are on a second-floor, mezzanine level right over the main lobby. The powers that be really don't do, honestly, don't do a good job. Where we get the recognition is from the line staff, the nurses, the doctors, the techs, the folks who are there on the floors or in the units giving care. They appreciate us. They know what we do.” [Frank, lines 219-223]

Frank refers to administrators as the people who do not really see chaplains for what they contribute to the organization. Instead, he identifies the nurses, techs, and physicians with whom he has more interaction as his support/recognition team. Interestingly, administrators traditionally make decisions about hiring and firing chaplains. If chaplains perceive administrators as “inaccessible,” then their value becomes paradoxical. Chaplains have value in theory and not in practice.

Many chaplains talked about their practical value in helping patients and staff. When thinking about work quality and potential, one chaplain recalls how surprised a supervisor seems at what a chaplain does. She discusses her perceptions of an encounter with the supervisor.

“It's kind of funny, my direct supervisor is very good at that. The system, it's sometimes more as if they're surprised. When we had two employees die this year and I did memorials for both of them, like I would do for a parish funeral I did what the family wanted. I involved the employee's department, I really didn't do anything differently than I would have for a church member, but administration was like, "Wow, that was really good." It was almost like ... I think spiritual care can be an afterthought. That's kind of an understatement. Then when you are out there and you are involved they're like, "Yeah, this is really good, this is really important." [Sheryl, lines 244-252]

Sheryl's response supports the paradox or perceptions. In her mind, she has created and executed a typical memorial service; in the minds of her administration, she has done something extraordinary. Additionally, her boss seems uniquely surprised that the job has done well, which implies that that the expectation was low.

An unexpected aspect of paradox involves work-life balance for chaplains who often get called during their “off” and “on-call” hours. Tricia recalls being frustrated with a coworker and having to deal with being called in while off-site.

“The work-life balance issue, I was on call a lot last week. More than usual. The work-life balance is hard. I got paged to care for a family that had just arrived, and when they paged me I was right in the middle of reading a bedtime story to my 4-year-old. Had to immediately stop and tell her goodnight, that I couldn't cuddle and I had to go to work. Which of course was heartbreaking for her and hard for me.

I tried to, in that, get some really touchy communication with the nurse. She pages me, I call back, and I have to figure out after hours, is this an emergency that I have to handle after hours or is this something that can wait until the next day? I had just been on for 12 hours the day before. I'm on overnight, and I'm going to be on for 12 hours the next day. It's not like someone else is going to be in in the morning. It's going to be me, and I can assure you I will go see them in the morning. Is this really a need where this is going to change between now and morning? Is this something where I need to come in, in what would be the only 12 hours of sleep and rest and dinner that I've got, and come back to work.

For obvious reasons, because I'm human, I would rather not come in if I don't have to. Not to mention, I don't get paid for coming in. Trying to communicate to that staff person, "We're available for emergencies after hours, is this something that can wait until tomorrow or do you think they really need to be seen tonight? I'm not on site." Trying to communicate the information to that nurse that he or she needs to make the best assessment that he or she can about whether I need to come in. Because they're there in the situation and I'm not.

Without sounding like I'm trying to avoid my job or without sounding like I don't care or don't want to come in. While I truly, in my heart, kind of don't want to come in. That's a tough communication situation in my opinion. That's tough for me. Sorting that out, doing that assessment and that triage and helping that nurse feel supported. Sometimes, the patient or family doesn't really need you at all, it's all the nurse that's stressed. It gets to be a hard call about how we manage our limited time. That's a tough communication situation." [Tricia, lines 381-412]

Tricia explains this situation with great difficulty. Although she loves her job, it can become difficult to determine when a coworker asks for chaplain-related help as compared to frustration or stress help. As an “on-call” resource, Tricia deals with trying to manage home life while also being tempted to go back to work earlier than expected. No matter which decision she makes, she sacrifices both home and work, as she cannot divorce herself from either. That is, if she goes to work, the guilt of leaving her daughter without cuddles remains; if she stays home to cuddle and sleep, the possibility that the patient or family is truly in need remains in the back of her mind. At that moment, Tricia prioritizes one over the other, even though both are important.

Just as there is no overtime pay for hospital chaplains, non-revenue generating is where they appear on the organizational financials. They do not directly bring revenue into the hospital from their services. Tricia talks about this briefly as she continues her interview.

“Yeah. I think as a non-revenue generating department we often fly under the radar until there's a really big problem. Then we're there to say the blessing on the tree that we plant because some staff member was killed at work. I think we have a lot to offer, I don't know that we always make that clear enough, high enough up that it then comes back our way, if that makes sense.” [Tricia, lines 302-308]

Along those lines, Barry describes the overall challenge of being a part of a department that is necessary, but not financially desirable. He talks about the challenges to understanding how to measure and track the success of chaplains in an organization that has multiple expectations.

“I think that the chaplaincy field is a very insecure field. We're not a revenue-generating department, if you will. We are a soft-skill and much needed, nevertheless, but ... We're constantly measuring what we do, how we do it. There are tools that we have to fill out.

How much time we spend on the encounter? What kind of encounter? We're constantly looking and splitting hairs over everything we do." [Barry, Lines 209-214]

The chaplain's work begins to develop this constant tension regarding contributions. Investments made into the careful spiritual provision and guidance also compete with issues of security, safety, and comfort. A hospital chaplain may address theologically complex questions in regards to life decisions, while also being asked to accompany a grieving family to the cafeteria for comfort. They may provide input on budget-related decisions, while also being left out of the conversation on effective health outcomes. Patients and coworkers perceive and assume they are necessary; however, they are aware they must perform effectively to avoid downsizing or phasing out during administrative cuts.

Paradoxes are illogical components of organizing, resulting in empowerment and beneficial to the organization (Jablin & Putnam, 2000). They provide alternative insight, stretch boundaries, and encourage a separation from traditional protocols (Wendt, 1998). In the chaplain's role, with all of its multifaceted functions, a paradox develops with respect to perceived utility. Chaplains stand inside a role that renders them as necessary and disposable. They must manage their role carefully to maintain a certain perception of need as paid employees. In addition to managing their role, they must also work toward gaining respect for their opinions and perspectives that may not match their medically trained co-workers. This can present challenges when working on interdisciplinary teams and projects. Even though the chaplains discuss the organizational benefits of their paradoxical situation, empowerment and paradox never appear together in the text or subtext.

With respect to them as individuals, the paradoxes likely contribute to their uncertainty because it is neither acknowledged nor handled (Trethewey, 1997, 1999). Each day brings new

challenges and situations that often compete with each other and lead to uncertainty. Uncertainty is an ever-spinning wheel in their subconscious minds and becomes conscious each time they have to argue for their interpersonal, departmental, or organizational value. Because their relevance is not always apparent to others, they must also battle for a voice at meetings or working with other departments on a task. Although these tensions can be frustrating, this unique position allows chaplains to be aware of their position, and their surroundings, to manage competing goals and perceptions of value properly, and may motivate them to focus on job effectiveness.

Addressing the Research Question

This research set out to one primary question: how do chaplains communicate at work? From this study, the simple answer to the question would be that chaplains communicatively act as liaisons by accommodating to their different co-workers on a constant basis in their work environment. They not only communicate, but also they effectively fit into each organizational work group. Using the findings above, hospital chaplains communicate through upward and downward convergence. Chaplains establish relationships with patients, patients' families, and co-workers from other departments by spending time talking with them and staying up-to-date on available information. As a result, these individuals are able to understand how to serve their co-workers and patients.

While not prevalent enough to create a theme, an important aspect of hospital chaplain communication involves a critical aspect of all organizational communication: meetings. When asked about their communication at work, almost all of them talked about relying on morning meetings for information and communication opportunities among team members. Those on shift

overnight could report, but also leave reports about anything else that happened. One chaplain explains how meetings are used.

“We meet each morning. The chaplain that was on call the previous evening gives a report, so we meet each morning for a half-hour to debrief that chaplain, to find assignments, to carry on the work they did through the night, and then a general check-in time of what's going So that's each morning with the entire department. Once a week I have a staff meeting with chaplain's staff that does not include chaplain residents, so we have a weekly staff meeting. Once a month, we have a departmental staff meeting, and usually on those monthly meetings, I'll give 15 to 30 minutes to a hospital administrator to just educate about other areas of the hospital, what's going on, and, I don't know, environmental services, or security, or food services, or building and development, or development, or ... It keeps us plugged in throughout the house.” [Spencer, Lines 65-75]

Another chaplain describes the monthly meeting process and the information exchanged.

“We have monthly, it's called management debriefing, so once a month all the people in the organization who are at the director level, which is my level, meet monthly and the senior team communicates to us the important stuff of the hospital. That includes customer service scores, financials, any special project that's going on, I can't think of what else are the regulars, and then any Q and A, and it's an hour and a half long meeting so that's a primary method. Email, and then we do the top down, so that monthly meeting with my direct boss, she has a template that's given to her from the CEO, and she's on the Senior VP Team, so that's kind of nice. They put together talking points to pass down individually to their managers, and those directors that report directly to them. Then the job is for me to communicate that to my staff.” [Topher, Lines 79-89]

For Spencer and Topher, their meetings exemplify the role of liaison that they play. In this case, the information exchange is prevalent as they take information from upper management back to their teams or other workers. Spencer also alludes to taking information from groups not present at the meeting table (i.e., safety, security) to administration. Because they are fortunate enough to have a seat at the table, they are able to minimize their need to reduce their uncertainty; hearing information first-hand and being able to ask questions are two uncertainty-reducing strategies.

Sometimes chaplains are in communication with other co-workers (outside of the pastoral team) where they get their daily information. Most of this communication occurs through mediated channels. Edward explains his experiences during his time with the hospice department from his over 30 years of service.

“Our hospice has done a lot of communication by voice mail with every morning until recently, but for 7 and a half years of my 8 years with hospice, every morning our office manager would leave a voice message at 7 am with a complete report that would say here's our numbers, how many we have in home care, how many in in patient care, here's our new admissions yesterday, here are the deaths that happened yesterday or overnight, here's anything that the teams need to know and then team members would leave voice message for each other.” [Edward, Lines 88-95]

Jordan explains the various ways he receives information from his boss and how meetings are times of information sharing. He talks about the use of reminders even after receiving the initial information.

“[My boss] is very very good at communication, communicating with us. He does a lot of email, we send email back and forth between him and us and there's also email from headquarters in [city], then there also is several bulletin boards in the building, in our

office. Notes and schedules and announcements are posted there as well. Reminders also in the morning and afternoon at staff meetings.” [Jordan, Lines 47-52]

While these channels are not unique to hospital workplaces or chaplains, they do represent the most common ways in which organizational members communicate with each other. Receiving information through multiple channels often helps organizational members reduce their uncertainty and enhance understanding.

Meetings also serve as an opportunity to explore, discuss, and plan. Stan explains how he and his team used meeting times to understand how to improve their jobs.

“At our meetings, there’s also a time there of the chaplain had an encounter that he wants to bring up and talk about. We debrief there and we try to talk about how best that might be handled next time.” [Stan, Lines 101-103]

Although spiritual matters are a common interaction, other times chaplains may be interacting on specific tasks for the organization. Nathan describes his interactions with co-workers on specific tasks that allow him to interact with his co-workers on non-patient related matters.

“Things that I have done, usually it involves presentations within groups. I have done new co-worker orientation, where we would talk about spiritual care, diversity, and inclusion, those kinds of things. I’m getting ready to do, on November 7th, a nurse residency class on nursing and spiritual care, that will be a 2-hour presentation. Other workings with staff outside of group committees or group sessions would be interacting with nurses and staff, communicating needs between patients or families, and so forth.” [Nathan, Lines 43-49]

Zach summarizes organizational communication best through the idea of “presence” and how to prepare for the current and upcoming moments you must handle as a chaplain. He describes the emotions experienced during an intense time.

“whenever you get a trauma page the first thing to do is take your own pulse. Early when I first started, you get a page about some horrific accident and your adrenaline would start pumping and your heart would start beating faster. You need to make sure that you're calm within yourself. That you're centered on the needs of the person you're about to speak with rather than your own needs. It's a challenge when you walk into a room where there is a person dying who is the same age as one of your own children. You have to realize and remain focused on the needs of the patient and the patient's family. You want to be centered spiritually in recognizing that God is at work in the midst of the situation, that we are willing to be available to Him. To be used in the life of these other people. There [are] some times that you just move very quickly from thing to thing and you don't have the opportunity to go through a checklist of things. I believe that experience has made some of that just a very automatic thing as you walk from one room to another or one patient to another.” [Zach, lines 75-90]

Heeding Zach’s advice about being present in every interaction has the potential to improve communication not just for the chaplains, but also for all hospital and organizational members. When people are present during a communicative interaction, they reduce their uncertainty, build or maintain their relationships, and better understand their role.

This section presents the findings of 16 long interviews with various hospital chaplains. The findings represent patterns found in the chaplains’ recalled experiences and interactions in their environments. Chaplains’ behavior exhibits both convergence and divergence as related to

communication accommodation theory. Chaplains also exhibit role-switching behaviors, which allows them to interact with different co-workers across the organization. They communicate for three concrete reasons: to build relationships, to better articulate and understand their roles, and to make sense of the paradoxical nature of being a hospital chaplain. These communicative interactions take place formally in places such as meetings and rounds as well as informally in locations such as walking down the hallway. They also occur in dyadic, small group, and even organizational contexts. Finally, the interactions accomplish task, relational, and identity goals associated with communication (Clark & Delia, 1979; O'Keefe, 1988). Given the large number of communicative interactions in which hospital chaplains participate and the expansive number of organizational members with whom they communicate, it becomes apparent why liaison is an accurate label for those who hold these positions.

CHAPTER FIVE: IMPLICATIONS

This study, designed to explore the lived experiences of hospital chaplains as liaisons who interact with many different people and groups of people daily, answers the single research question: How do they communicate at work? The interview data indicate that they communicate to achieve the instrumental, relational, and identity communication goals (Clark & Delia, 1979; O’Keefe, 1988). Their instrumental goals involve typical tasks such as performing rituals, providing spiritual care to patients and staff, and participating in meetings. Unexpectedly, they also engage in task-related communication in areas such as security, organizing the emergency room, and interacting with departments such as security and the coroner’s office. Hospital chaplains, not surprisingly, spend large amounts of time engaging in relational communication. They build these relationships as they provide emotional support; engage in difficult conversations with patients, families, and staff; and converse with other staff to ease the tension after a crisis or build rapport. Finally, hospital chaplains utilize communication to achieve their identity goals, particularly with respect to the paradoxical situations in which they find themselves. They must be willing to advocate for their own position as a valued member of the healthcare team, a necessary expense in the hospital budget, and people who have lives outside the hospital environment. As they achieve these communication goals at work, they often engage in converging communication to minimize differences while maximizing similarities between themselves and the others with whom they interact.

The sheer number of others with whom they interact helps define them as liaisons in the healthcare organization. As defined at the beginning of this study, liaisons bridge different departments, hold credibility and expertise, and communicatively interact with multiple co-

workers on a consistent basis (Jacobson & Schwartz, 1977). As indicated in the interviews, chaplains may find themselves bridging employees who do not have a seat at the decision-making table and administrators as part of inter-disciplinary team meetings. They may also serve as the bridge between a higher spiritual being and a patient or family member or even between the patient and family members. With respect to spiritual care, they hold a high level of credibility and expertise in almost all of the situations described; a notable exception is the emergency room chaplain who perceives the manager does not afford him credibility or expertise. Finally, chaplains have very few restrictions in the hospital context so they are able to interact with many people to whom other employees do not have access. As liaisons, they have abundant opportunities to contribute to the organization's mission and reach many organizational stakeholders.

Research Contributions

This study contributes to the current bodies of organizational and health communication research. Communication accommodation theory (CAT) is discourse- and interaction-centered, looking at interpersonal communication as a process of interaction between members (Baxter & Braithwaite, 2008). The theory takes a social focus in studying the substance and purpose of messages in communication as enacted between individuals. Finally, CAT is applicable to multi-disciplinary communication in the workplace as well. Ayoko, Hartel, and Callan (2002) argue that “the type and course of conflict in culturally heterogeneous workgroups is impacted by the communicative behaviors and strategies employed by group members during interactions” (p. 165). Within the hospital environment, departments (e.g., nurses, physicians, administrators) are different work cultures with their own sets of jargon, behaviors, and speech codes. An employee may perceive a coworker as being unfriendly or untrustworthy if that coworker is non-

accommodating. Alternatively, chaplains may increase others' job satisfaction and relational quality at work by accommodating others and highlighting similar interests when working together.

While this study does not develop a new theory, it extends the explanatory power of theory by applying the concepts of converging (accommodation) and diverging (non-accommodation) in the healthcare setting. Traditionally, this theory has focused on discussing topics within intercultural and group communication interactions. However, this study explores the use of messages as they relate to the expected roles of the chaplain position. In other words, this study highlights the use of convergence specifically, and divergence to a lesser extent, as an organizational norm. Hospital chaplains as liaisons who interact with people in all organizational areas must be able to adapt their communication to meet the needs and expectations of those around them. They must be able to float in and out of groups seamlessly to succeed at work. Thus, this study begins to extend CAT by focusing not on a single group, but rather on how people accommodate multiple groups in the course of a single workday.

Practical Contributions

The findings from this study reveal an interesting dynamic for the hospital chaplain. Not only are these individuals in their environment to work, but also they are available as social and organizational resources. Their high amount of connection within the network, along with varied communication interactions and expectations, leads to a unique organizational position. Chaplains, on a daily basis, interact with patients and their families, nurses, physicians, social workers, other community clergy, volunteers, hospital administrators, and environmental and food service workers. This internal and external connection becomes one that allows these, and only these individuals, to interact with people no one else can. Chaplains bring a unique

perspective when involved with interdisciplinary teams (Wittenberg-Lyles, et al., 2008); they offer insight the hospital's inner workings based upon the interactions they have with both internal and external stakeholders. Additionally, this study reveals that their unique role also allows them to communicate effectively with diverse others in the workplace.

Chaplain-physician relationships and reciprocity in work interactions may foster more positive relationship perspectives (Carey & Cohen, 2009). This study reinforces the idea as chaplains frequently referred to themselves as resources and helpful "aids" to the hospital environment. In other words, this line of research contributes to the conversation that legitimizes the need for chaplains as solid contributors to the hospital environment. More importantly, it also encourages perspective changes from other workers who may not be as convinced. For example, nurses or technicians may wonder why they do not get a patient's undivided attention when entering a patient room if the chaplain is present; this research reinforces the role chaplains play in the healing and dying processes. Similarly, the chaplain is on the front lines with the nurses and technicians and can advocate for them in inter-disciplinary team meetings as potentially the only ones who have first-hand knowledge of what these co-workers experience in their everyday work interactions.

Another issue raised is the utility of the chaplain in the hospital environment. Standard expectations assume the chaplain directly relates to spiritual matters (Davoren & Carey, 2008). However, this research study shows several responsibilities not related to spiritual matters. In other words, the work of the hospital chaplain is both spiritual (providing emotional support) and organizational (participating in decision-making groups). Chaplains also find themselves fulfilling interpersonal needs for others. As noted, chaplains become a "listening ear" for many within their environment; they can become gatekeepers of personal information and create

interpersonal connections. For example, these chaplains may serve as the sounding board for employees who want to initiate change and are unsure of how to approach others in a higher position. Similarly, they may also be the ones who are there to provide support or comforting messages when an employee feels undervalued or has just finished a mentally exhausting patient situation.

These unique individuals, a preferred choice to talk with, garner different patient and co-worker perceptions because they are not medical professionals. Essentially, they possess social credibility not given to a physician or hospital administrator. Even among their co-workers, they provide utility when they serve as resources for tasks not generally in their area (i.e., helping someone find the right floor, accompanying a worried family member to the gift shop). Like many others in helping professions, for example teachers, social credibility can have an adverse effect. Because many helping professionals lack job security, they also find themselves in situations where their lack of job security and perception of being dispensable in a budget fight lead to changing relationships between chaplains and their hospital organizations (Huberman & Vandenberghe, 1999; Leiter, 1999). These changing relationships also lead to a change in how chaplains view their work and attach meaning to it. Finally, social credibility has the potential to lead to burnout because of the increased workplace demands that arise as a means to prove their worth and because of their connection to so many people in the organizational setting.

Solidifying the role of the chaplain is also another issue where the findings from this study can contribute implications for this position within the hospital workplace. One difficulty is separating and defining the difference between the spiritual care they provide and the spiritual care that medical professionals (i.e., nurses and physicians) could provide (Mohrmann, 2008). In other words, hospital chaplains find it challenging to show that what they provide to patients is

significantly different from what other medical professionals can give to patients. As a result, this creates a perception that the need for a chaplain, or the usefulness, is not highly demanded as any spiritually related individual could administer their services. Although this creates a difficulty, Mohrman discusses the distinction between what gives the hospital chaplain legitimacy as a professional and individual within the hospital. Chaplains serve as the only Spiritual Care Specialists who have been educated and trained specifically to deal with matters of a spiritual nature. As a result, this creates a niche where the chaplain can argue for a solid place in the organization for the specialization that they bring.

In regards to this study, the findings reveal not only how well chaplains provide spiritual care, but how naturally chaplains handle matters considered secondary to medical professionals. Patients rate their satisfaction at its highest, on four factors of satisfaction, when they receive religious and spiritual care, regardless of whether the patient requested the care (Williams, Meltzer, Arora, Chung, & Curlin, 2011). Chaplains recall times where they could help serve patients, patients' families, and co-workers with mainly spiritual needs. Additionally, these individuals also seek out the chaplains for spiritual care and guidance or as a listening ear. The idea of providing *quality* spiritual care is one that raises the issue of learning how to measure the working contributions of a hospital chaplain (Lyndes, et al., 2008). Like any other professional role, there are listed responsibilities and expectations involved with this position. However, there are multiple role expectations that deal both directly and indirectly with spiritual care. Providing patient spiritual is the primary concern of hospital chaplains; however, in addition to that, there are many other responsibilities that are included (i.e., interdisciplinary meetings, servicing other employees, and connecting with community workers). Therefore, measuring the quality of work

becomes a complicated process not easily priced. What counts as quality care? What does not count? Whose standards determine worth and how do we standardize those calculations?

The chaplains' recollections illustrate how they can better define the idea of quality spiritual care. Their expertise and knowledge during times of crisis, grief, and conflict raise a special set of situations that allow them to stay in demand. Hospital chaplains could begin to develop a typology of instances where they are highly successful and in demand. The measurement of these occurrences would also allow hospital administrations to track their success. Tracking this department would lead to assisting with a major concern of the hospital chaplain, which is the non-revenue generating stigma. In other words, these individuals, not officially recognized as a revenue department, do contribute indirectly to the operating budget because they add quality to other revenue-generating departments. For example, when a chaplain is able to help resolve spiritual concerns or conflicts with a patient and the family, that hospital can expect higher patient satisfaction scores, which can lead to consistent use of that hospital from patients. Similarly, when a chaplain assists a nurse in communicating with a patient about a health procedure, that chaplain has indirectly affected the quality of the nursing service and possibly helped a patient see the need for a procedure that was dismissed previously (revenue-generating behaviors). Therefore, chaplains may have the ability to define their own quality and have their contributions connected to the revenue-generating departments.

In summary, the hospital chaplains occupy a unique organizational role. They enhance patient satisfaction, execute a variety of responsibilities for internal and external stakeholders, and indirectly generate hospital revenue. Chaplains hold a varied knowledge when it comes to communicative interactions between and among departments, which allows them to become the “glue” of the organization by functioning as liaisons within the hospital.

Limitations and Future Research

This research study set out to explore the role of the hospital chaplains to understand the communication behaviors in the workplace and better understand what is included in their role responsibilities. Although this study is complete, it is not without limitations. One of the limitations to this study is that this study only includes the chaplains' perspectives. Although this is a strength in a way, the participants possess a limited perspective on their job role. Future research, then, should take into consideration others' perceptions of the hospital chaplain (e.g., nurses, physicians, and patients). Similarly, the study only takes into account chaplains who work with hospitals. Thus, this study focuses on one kind of organization and cannot be generalizable to other organizations. In other words, the findings are limited to the hospital and healthcare environment. This excludes the role of other chaplains who work in environments such as prisons, military, politics, and academic institutions. Future research in this area should look at the role of chaplains in these organizations to see if similar communication behaviors are present. Third, the sample size limits the study's generalizability. As indicated earlier, the study does not address the nuances of different-sized hospitals, different-sized pastoral care staffs, or the differences that may exist across a variety of demographic characteristics such as sex, race, years of experience, or spiritual affiliation. In other words, these data reveal patterns across hospital chaplains and may not be completely representative of all hospital chaplain experiences. Future research should consider larger, survey method research to help support some of the data found in this study and continue exploring the chaplain's role.

Future research using communication accommodation theory should look at social linguistics and interpersonal complexity among working individuals. For example, research can examine the ability of chaplains to accommodate their language from jargon-heavy medical

terminology into the common language of the patient. The effectiveness of communication within physician-chaplain working relationships, or even chaplain-nurse relationships, brings a better understanding of communication within workplace environments. Additionally, understanding the processes of convergence and divergence in the work environment enhances our knowledge and practice. Although CAT research has explored supervisor-supervisee relationships, the relevance within co-worker or horizontal relationships remains untapped. As hospital chaplains work with individuals from different departments within the organization, their accommodation (converging and diverging) may be the contributing factor to their effectiveness in completing tasks and helping the environment function properly.

Future research should also focus on data-driven studies to determine the strength of the hospital chaplain's role. Hospital chaplains should be able to show not only their ability to complete their responsibilities, but also effectively contribute to other departments' success. It would also be helpful to have a model that would show which departments hospital chaplain interactions affect most; chaplain's departments would be able to show how their contributions influence budget. For a non-revenue-generating department, this would be helpful in putting the measurement of their success into a related dollar amount. It may also help legitimize the purpose of these departments and add them into the hospitals across the U.S. who currently are not motivated to add this department into their budget.

Finally, future research should focus on using chaplains in emergency and security situations. Hospital chaplains may operate as de-escalators, individuals who are able to decrease the intensity of situations considered dangerous or intense. Since chaplains are educated in crisis management, these individuals are effective in working with people and managing emotions during this time. Communication strategies and effectiveness during hospital crises may suggest

how chaplains handle non-spiritual situations. This may also help reveal more details about interactions between co-workers and chaplain staff.

Summary

The purpose of this study was to explore the communication behaviors of hospital chaplains in an effort to understand the chaplain's role and communication behaviors in the hospital setting. To complete this study, previous literature in communication and health introduced the concept of the hospital chaplain and laid the groundwork for exploring their communication behaviors and functioning in the hospital workplace. The researcher conducted interviews with 16 diverse hospital chaplains recruited through the public Facebook group page for the Association of Professional Chaplains, personal contacts, hospital web pages, and snowball sampling. Recorded and transcribed interviews, using pseudonyms for confidentiality, comprise the data set. The research, in conjunction with two research assistants and two coders, analyzed and coded from concepts into themes. The three themes of role management and uncertainty, building relationships, and paradoxical interactions reveal the multi-faceted nature of hospital chaplain roles. From a communication perspective, the narratives illustrate the ways in which hospital chaplains use communication accommodation, and to a lesser extent non-accommodation, to achieve their instrumental, relational, and identity goals. Because chaplains serve as internal and external hospital liaisons, their unique organizational position allows them to build relationships with many diverse individuals and use that knowledge to contribute back to improving the organization's operations.

This study contributes to the fields of organizational and health communication by highlighting the need for the hospital chaplain in the organization. Additionally, it spotlights the role of chaplains as so highly versatile that it may be possible to understand their utility in the

workplace. By referring to chaplains as liaisons, the complete value of their role comes to light. These unique individuals use communication effectively to better the organization. By interacting with various people in their environment, and being able to accommodate each, they accomplish tasks that their coworkers are not able to do. A major part of those tasks is achieving shared meaning with people at multiple organizational levels. Therefore, this study illustrates the variety of people with whom chaplains interact: patients, their family and friends, medical professions, administrators, volunteers, and staff. These interactions fulfill the study's liaison role and allows them to help improve communication between departments or understanding about various communication situations.

Future research in organizational communication should look at the role of the chaplain in terms of defining the quality and effectiveness of their work output. In addition, research needs to develop a measurement model to standardize the work of hospital chaplains in terms of measuring effectiveness and influence on organizational budgets. Future research in health communication should look at the patient satisfaction scores across a variety of chaplain or pastoral care possibilities (e.g., hospitals with fully and partially staffed chaplain departments, denominational and secular hospitals, experience levels of chaplains, etc.). This would help continue the conversation on understanding and solidifying the hospital chaplain role as one of organizational liaison.

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APPENDICES

Appendix A
Interview Protocol

Tell me about your responsibilities with your institution.

If I were interested in becoming a hospital chaplain, how would you describe the job to me?

With whom did you communicate at work yesterday?

What department(s) do you report to?

How do you communicate with them?

As a chaplain, whom do you serve?

How was yesterday similar to most other days? How was it different?

Can you talk about your interactions with the different team members?

How do you stay informed about decisions being made at your institution?

Where do you receive information about the institution?

What information do you have to look for or seek out?

Where do you go when you need to know something about the organization?

Tell me about a time when you've had to switch roles (e.g. Reverend, to counselor, to crisis, then back etc.)

How do you communicate during these times of going back and forth?

What considerations do you make when communicating with different co-workers?

What changes when you stop communicating with hospital employees and start communicating with families or patients?

What do you say or do around patients and families that you would not say or do around hospital employees?

How does your communication change when you deal with people outside the hospital in the community?

Tell me about a time when you felt especially valued as a hospital chaplain.

What did someone say that made you feel valued or an important part of this organization?

Tell me about a time when you felt especially undervalued at work.

What did someone say or do that made you feel not valued or an unimportant part of this organization?

How, if at all, has the situation changed?

Does this department (person) interact with you regularly?

If yes, how do you communicate with them?

You get to see both sides of the health institution, how does that help you communicate with the different people you interact with?

Can you recall a particular instance where this occurred?

What are the most positive aspects of your job?

What aspects of your job are most challenging?

Can tell me about times when you feel it is challenging to communicate with any of your co-workers?

How do you manage interacting with them?

What else do I need to know to better understand what it is like to be a hospital chaplain?

Age

Sex

Ethnicity

Appendix B
Analysis Coding Book

Code Book: Hospital Chaplains	
Communication Behaviors	
Morning Meetings	Daily meetings where communication takes place. Involving anything happening overnight, important news, and administration announcements.
Serving patients' families in times of need	Being a constant and consistent line of communication for patients and their families. Interactions that can only be managed properly by the role of a chaplain.
Email/Newsletter	Primary communication channels used. Email and hospital organization newsletters include most of the information used for chaplains to know about their environment.
Serving Staff /Co-workers	These are the interactions where chaplain's duties are directed towards a staff member or coworker who is in need.
Interdisciplinary Team Meetings	Teams where chaplains participate and interact with medical professionals. These are medical or administrative teams that help keep chaplains informed of other departments or understand new goals of the hospital
Role-Management	
Natural Interaction/Common	Seen as an everyday experience. Natural occurrences that they feel prepared for and have become accustomed to it as a part of their job.
Being Present	Being consciously aware of the moment they're in. Pushing other things aside and attempting to live the moment for what it is at that time to give the patient/person what they need.

On-Call Duty/Sacrifice (Work-Life Balance)	The expectation of always being available. Also the moments where a chaplain's personal life is interrupted in order to respond to any issues/crises happening on the job.
Patient Advocacy	Putting the patient first, and making sure to think of the patient's best interests when making decisions or dealing with patients. Also making sure that the patient's perspective is understood when any misunderstandings occur between patients and medical professionals. Showing high concern for privacy of any shared content and sharing information with the right people.
Bridged Reports	When information from patients is shared with chaplains because they feel comfortable mentioning it. Chaplains then make sure that any necessary information is reported to the proper department or individual (social worker, police, nurse, physician, etc.).
Expressed Value	
The "Almost" Thanks	The expression of value from those <i>within</i> their department, but a struggle to identify points of appreciation from other departments. Assuming that you are valued in some way, but not able to find instances where it's explicit.
After-thought Interactions/Implicit Exclusion	Being informed about situations/interactions too late or after the moment has already passed. Feeling "left out" or ignored by other co-workers.
Advantages/Challenges	
Liaison Communication	This is where chaplains are able to take advantage of their connections to help individuals reach mutual understanding, by translating information from one perspective into the language of another perspective.
Chaplains as universal resources	This is the idea where chaplains are used as "resources" or staff members who are most likely able to help an individual.

	Moments when patients (or others) are passed off to chaplains
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VITA

Stephen Spates was born to Deborah Lewis- and Ronald Spates, Sr. in Detroit, MI. He is the last of three children, with an older brother and sister preceding him in birth. At the age of 7, he and his family moved to Berrien Springs, MI where Stephen received the bulk of his education for his elementary, middle, and high school years. After spending 12 years as a student in a Christian, private school system, Stephen graduated from Andrews Academy and left for college. He ended his high school matriculation with recognition for community service, great character, and potential for success.

After completing high school, he continued his education at Oakwood University in Huntsville, AL. There he received a Bachelor of Arts degree in Communication Arts with a Minor in Management. Stephen graduated, Cum Laude, and with recognition for many achievements for leadership and campus involvement. He left Oakwood with a job offer and acceptance into graduate school. However, Stephen accepted a second internship with a Healthcare Marketing team to gain field experience. He later decided to return to school and complete a master's degree.

Stephen was accepted into the Master of Arts program in the School of Communication at Western Michigan University in Kalamazoo, MI. He was also the recipient of the Thurgood Marshall Graduate Fellowship which covered tuition and carried a stipend. During his program, he received teaching experience and graduate school coursework in communication studies. Stephen completed his Master's in Communication Studies after completing a thesis. He was recognized as an All-University Research Scholar, Outstanding Teaching Assistant Mentor, and Research Associate. At the end of this program, he made the tough decision, not to return to industry and switch career paths to academia. Stephen decided to continue his graduate work and pursue a doctorate degree.

Stephen was accepted into the Communication Studies program in the College of Communication and Information at The University of Tennessee in Knoxville, TN. He was also the recipient of the

University Fellowship which allowed him to attend with full tuition waiver. During his program, Stephen continued to receive teaching experience in a variety of communication courses, along with taking coursework of his own. After 2 years, he successfully completed his comprehensive exams to become a doctoral candidate. Stephen graduated from The University of Tennessee with a Doctor of Philosophy degree in Communication and Information, focusing in Communication Studies and an emphasis in organizational communication. He was recognized as a Student Life Courage to Climb awardee for excellence in organizational leadership and an Outstanding Doctoral Student in 2016.