17 Communication in the Helping Professions

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We now live in a society driven by a service economy. Following the Industrial Revolution, most workers toiled at creating “things” through manufacturing, but today, the service sector drives the economy, particularly in the United States and other Western nations. As Meyer and DeTore (1999) reported, “The service-producing sector continues to lead projected employment growth and...the 10 leading industries, accounting for 60 percent of all projected job growth over the coming decade, are all service producers” (p. 64). Moreover, much of the “service” provided involves more than selling a cheeseburger, entering data, or making flight arrangements; instead, it requires intensive physical and emotional involvement between service providers and their clients. Workers involved in the provision of human and social services are employed in what are called the helping professions.

Individuals with these types of jobs provide many kinds of assistance to others that fulfill a variety of physical, mental, social, and economic needs. However, across all of these professions, the provision of help requires an interpersonal relationship between the provider and client, and, consequently, to a large extent, this work—at its heart—is communicative. More than 2 decades ago, Thompson (1984) introduced the communication discipline to the “invisible helping hand” of the health and social service professions. Thompson pointed to the paradox that the helping professions were centrally about communication but had been all but ignored by communication scholars. Since Thompson’s critique, substantial research—both within the communication discipline and other disciplines—has examined the role of communication processes in the helping professions. This work about the ways in which communication processes give aid to those with physical, social, mental, and emotional needs is representative of applied communication in a very fundamental way. Thus, in this chapter, we review and synthesize that research, and argue for an understanding of the “compassion work” performed by individuals in helping professions that is grounded in the constitutive and instrumental functions of communication.

In the literature we consider in this chapter, we do not hew to a strict occupational definition of the helping professions. There are, of course, some jobs that clearly fall into this category, including social workers, nurses, nursing aides, physicians, counselors, and ministers. Occasionally, we consider literature on teachers, but given the huge scope of the education literature, the wide variety of educational roles, and the coverage of this topic by Darling and Leckie in this volume, our emphasis is on other careers. Our selection of literature to review, however, stems not from specific job categories but from an understanding of “what is done” on the job. Furthermore, we use the term profession in a very loose sense; although it is possible to consider specific factors that demarcate professionalization (e.g., self-governance, advanced training, and organized associations), we look more generally at anyone who engages in “helping” as a living.
We divide this chapter into three major sections. First, we consider the foundations of the helping professions by examining their historical development, their basis in theories of morality, and the motivations of individuals entering them. The second major section—the heart of the chapter—considers the communicative relationship between providers and clients in the helping professions, looking at models of the helping relationship and specific communication choices made by those performing human and social service jobs. The final section explores issues of context in the helping professions by considering ways in which service-provision groups and teams, organizational structure and culture, and institutional and systemic processes can influence the work of helping professionals.

The Foundations of the Helping Professions

The foundations of the helping professions can be considered both chronologically and in terms of the values that undergird work within these professions. In this section, we first consider the historical development of the helping professions and then discuss issues of moral development that serve as a basis for this type of work.

Historical Development of the Helping Professions

Some of the helping professions we consider in this chapter have a long history, both in terms of the provision of help in relationships and in society’s acknowledgment of the work as “professional.” These are the professions of medicine (see Kreps & Bonaguro, this volume) and ministry, which, along with law, are widely regarded as the original and classic professions (Haber, 1991). These professions involve significant postgraduate training and certification of both technical skills and understanding of professional standards through licensure or ordination.

Historically, these professions have been dominated by men. For example, Steward, Steward, and Dary (1983) noted that “until recently, when women chose a career in one of the helping professions, they worked primarily in the ‘number two’ spot, such as the role of nurse in medicine” (p. 166). Although some barriers still limit women from working in these original helping professions (e.g., ordination rules in some religious denominations), increasingly, women are assuming the primary roles in both medicine and ministry.

The other helping professions we consider have more recent histories. For instance, although many of the functions of nursing have been performed throughout human history, the profession of nursing came into existence in the 19th century. In the United States, professional nursing often is dated to the Civil War and the work of Clara Barton, with Florence Nightingale seen as the founder of nursing in Europe. Professional social work began in the early 20th century as societal attitudes toward the poor and indigent began to shift. As Csikai and Rozensky (1997) explained, “Instead of viewing pauperism as a flaw of moral character, fledgling social workers came to believe that many environmental factors were involved that led people to be poor” (p. 529). Thus, the social work profession began with an interest in social justice and improving environmental conditions for the poor (Bogo, Raphael, & Roberts, 1993), although social work has grown to include advocacy for a wide range of population groups. Many of the other helping professions have developed even more recently. The prevalence of nursing aides, for instance, has increased as nurses became more “professionalized” and shifted some responsibility for hands-on care to those with less training. Furthermore, some helping professions developed as specialized arms of traditional professions; for example, Woodruff (2002) discussed the specialized role of pastoral counselors, mental health professionals with extensive religious and/or theological training.
Several historical trends have contributed to the growth of the helping professions in the last 100 years. The most important of these trends is the shift in “caring” from the private sector to the public sector. Before the 20th century, care was provided almost exclusively in the home, even for the very sick and dying. Indeed, early hospitals were little more than places where the indigent sick (and sailors passing through) could be warehoused, with little care provided there. However, in the early years of the 20th century—with the urbanization of U.S. society and the rapid development of medical treatment and technology—hospitals became locations for the treatment of acute illnesses and injuries rather than mere holding pens for the sick and poor. This medical shift (Rosenberg, 1987) increased the need for professional caregivers and coincided with an increased number of women receiving higher education in fields such as nursing and social work. As Austin (1988) noted, “An expanding labor force of women with advanced education... made the development of new kinds of human service organizations possible” (p. 551). In addition to these general societal shifts, U.S. government policies and programs also increased the prevalence of human service organizations and individuals working in the helping professions. For example, New Deal legislation in the 1930s and 1940s (e.g., the Social Security Act of 1935) and Great Society legislation in the 1960s (e.g., the introduction of Medicare and Medicaid) increased the prevalence of public assistance and, hence, the number of individuals working in this type of career.

Finally, ongoing shifts in demographics (e.g., the aging of the Baby Boom generation), medicine (e.g., the increasing prevalence of chronic diseases as opposed to acute diseases), and family structure (e.g., fewer children, dispersion of families, and decreased reliance on family members as the sole providers of care) continue to increase the importance of care provided in institutional settings. The increasing importance of caregiving organizations and institutions and the helping professions is borne out in the patterns of employment statistics. For example, the U.S. Bureau of Labor (2005) estimates that jobs in all sectors of the economy will increase by 14.8% by 2012, but jobs in community and social services will increase by 26.2%, jobs for health-care practitioners will increase by 26.0%, and jobs for health-care support occupations will increase by 34.5%. In short, the helping professions are a critical feature of U.S. society today and tomorrow. The next two sections of this chapter, then, consider questions of why care is provided at a societal level and why individuals are motivated to enter the helping professions.

The Moral Basis of the Helping Professions

The question of why people—as a society and as individuals—choose to help others and provide care has been of interest to moral philosophers, sociologists, and psychologists for many years. Although the scope of these issues is far beyond consideration within this chapter, several areas of research are worth a brief look. For example, McGaghie, Mytko, Brown, and Cameron (2002) examined the related concepts of compassion and altruism as moral bases for the health professions. These scholars viewed compassion as the inner psychological motivation for the performance of altruistic acts. Compassion, with its basis in a variety of religions and moral traditions, including Buddhism, Christianity, Hinduism, Islam, and Judaism, typically is related to the concept of empathy—feeling a cognitive or emotional connection to another person and wanting to act on that connection. Indeed, Kanov et al. (2004) recently developed a model that conceptualized “compassionate motivation” as involving noticing, feeling, and responding. Compassion is seen as a central psychological motivator for those in the helping professions; McGaghie et al. (2002) speculated that “compassion not only leads one to a career in the health professions but also maintains career enthusiasm” (p. 375).

In a similar conceptual domain, the notion of altruism, typically defined as acting
on behalf of others rather than for one’s self, has engendered a great deal of debate in the philosophical, sociological, and psychological literatures. Some scholars point to the many ways in which individuals perform acts that could be regarded as altruistic. For example, Oliner (2003) considered the motivations and behavior of rescue workers during the Holocaust, individuals who had won the “Carnegie Hero” award, and a host of others who acted altruistically, concluding that these individuals were motivated by factors such as behavioral norms inculcated through their parents and the wider community in which they were raised, social responsibility, empathy, and religious belief. Other scholars, however, have argued that all apparently altruistic acts ultimately are performed because they are pleasurable, reduce empathic distress for the helper, or because of an egoistic desire to help others (e.g., Cialdini, 1991; Kenrick, 1991; Wakefield, 1993). Undoubtedly, most people who do good acts have a mix of altruistic and egoistic motives, motives that are developed throughout socialization. As Wilson (1993) noted:

Almost all of us encourage our children to acquire other-regarding motives. We do so in part because it is useful: generous people attract more friends and better opportunities. But most of us also do so because we think such motives are good in themselves. We want our children not only to be praised but to be praiseworthy. (p. 31)

A consideration of the moral basis of the caregiving professions also must consider the ongoing debate regarding the ethics of caring. This debate began in earnest when Gilligan (1982) published her well-known book, In a Different Voice: Psychological Theory and Women’s Development, in which she argued that conventional moral theory (e.g., Kohlberg, 1984) neglects the perspective that women typically use in their moral reasoning, decision making, and other behavior (see Buzzanell, Meisenbach, Remke, Sterk, and Turner, this volume). Conventional moral theory, Gilligan contended, is based on a hierarchical system that lays out moral development in terms of increasing attention to fairness, rights, and rules, and involves the application of attributes such as impartiality and universality. In contrast, scholars expanding on Gilligan’s work (e.g., O’Brien & Hallstein, 1999; Puka, 1990; Tronto, 1987, 1993; Wood, 1994) have developed an alternative model of morality. Tronto (1987) identified the essentials of this “ethic of care”:

First, the ethic of care revolves around…responsibility and relationships rather than rights and rules. Second, this morality is tied to concrete circumstances rather than being formal and abstract. Third, this morality is best expressed not as a set of principles but as an activity, the “activity of care.” (p. 648)

In sum, the moral basis of the helping professions can be found in the psychology of compassion, the altruistic (or possibly egoistic) motivation to care for others, and a morality that highlights responsibility in relationships. These ideas provide the basis for moving care from the private realm of the home into the public sphere of organizations and institutions, and for providing care across a wide spectrum of societal groups. Questions remain, however, about what motivates individuals to become caregivers in the helping professions and how individuals who choose these careers are socialized into them. The next section considers these questions.

**Individual Motivations and Socialization into the Helping Professions**

To a large extent, the moral basis of the helping professions discussed above also explains the motivations of individuals entering the helping professions. For example, a study of
motivations for entering medical school by Vaglum, Wiers-Jenssen, and Ekeberg (1999) found that the most prevalent motivation was being “people oriented” rather than being motivated by status, economic security, or interest in the natural sciences. Similar findings have been noted for other helping professions, such as social work (Csikai & Rozenksy, 1997; Hanson & McCullagh, 1995; Leichtentritt, Davidson-Arad, & Wozner, 2002; Perry, 2003), ministry (Steward et al., 1983; Ventimiglia, 1978), and teaching (Scott, Cox, & Dinham, 1999). These and other studies support the general contention that a large part (although certainly not all) of individuals’ motivations to enter a helping profession rests on idealistic visions of altruism and providing skilled service to others. Hanson and McCullagh (1995) concluded with regard to social work that “altruism, social idealism, and a commitment to social change are major factors in opting for social work as a career” (p. 28).

In some cases, however, the experience of socialization into the helping professions may deal a serious blow to people’s altruistic motivations. A number of scholars have talked about the “fate of idealism” in both medicine and social work (e.g., Wagner, 1989), arguing that the training process itself or early experiences on the job can undermine people’s original ideals of compassion and altruism. Wagner (1989) found that, for social workers, the drop in idealism came in the early years on the job, when new professionals found that their desire to promote social change often was thwarted by bureaucratic structures and economic conditions. For medical students, idealistic visions may be obscured even earlier in training, with Woloshuck, Harasym, and Temple (2004) finding a significant drop in attitudes during the course of medical school about the importance of physicians’ communication and relationships with patients.

What is the nature of socialization into the helping professions that could engender such changes? The majority of research on this question has focused on medical school rather than other helping professions, and many of the accounts of the medical school experience are anecdotal in nature (e.g., Jauher, 2008; Klass, 1987; Konner, 1987; Rothman, 1999; Shem, 1978; the essays in Takakuwa, Rubashkin, & Herzig, 2004). These memoirs, along with other, more systematic accounts (e.g., Becker, Geer, Strauss, & Hughes, 1961; Haas & Shaffir, 1987; Harter & Krone, 2001; Light, 1983; Scheibel, 1996; Smith & Kleinmann, 1989), however, provide rich data that allow several generalizations about the socialization of physicians. First, medical training is an arduous process spanning preclinical training in the first 2 years, clinical rotations in the second 2 years, and postgraduate internships and residencies that can encompass several years or even a decade. Second, a great deal of the learning that occurs in medical school involves not the formal curriculum but an implicit curriculum of values and ideology (Hafferty & Franks, 1994) communicated through role modeling (e.g., Harter & Krone, 2001), an ideology of excellence (Scheibel, 1996), and the informal interaction and stories told by other medical students (e.g., Hafferty, 1988). Third, this informal curriculum often involves learning strategies for managing the emotional strains of a helping career through intellectualization, objectification, and the cultivation of “detached concern” (Lief & Fox, 1963).

Although it is impossible to generalize these results regarding medical school to training in careers such as nursing, social work, and counseling, similar concerns have been raised about these other helping professions. For example, Wyatt (1978) noted the “perennial” problems in nursing education of the dichotomy between theory and practice, and the tension between empathic caring for patients and the reality of professional life. Socialization processes also extend beyond formal time in school to the jobsite and, in some professions, involves continuing education regarding a wide range of communication issues (for a review, see Cegala & Broz, 2003; for a specific example, see Goodridge, Johnston, & Thomson, 1997).
This brief consideration of the motivations and socialization of individuals into the helping professions points to the importance of compassion, altruism, and relationships as factors that motivate individuals to enter helping professions and demonstrates the extent to which these impulses can be altered through socialization processes and initial experiences on the job. In the next section, we look at how individuals working in helping professions enact these principles—tempered or not—in their communication with patients and clients.

Communication in Helping Relationships

Helping professionals often enter the lives of their clients just when these clients are facing some of life’s greatest struggles, including diagnosis of an illness, death of a loved one, job loss, or intense poverty. Because of the significance of these issues, practitioners in the helping professions need to develop relationships with their clients. These relationships often become central to task accomplishment—indeed, in many cases, the relationship itself is the primary task. For both the helping professional and the client, successful navigation of the helping relationship requires careful attention to the processes of communication. In this section, we consider the nature of communication in helping relationships and the consequences of various therapeutic interactions. We begin by considering two models of care within helping relationships, then examine both the content and processes of communication within these relationships, and conclude by considering ways in which communication in the helping professions may be both highly satisfying and highly stressful for care providers.

Models of Care

An analysis of the research on communication in the helping professions reveals two predominant models for the caregiver–client relationship. The dominant model has been termed both the “professional agency model” (Adelman & Frey, 1997) and the “medical model” (Meyerson, 1994, 1998; Walker, Arnold, Miller-Day, & Webb, 2001). In contrast, an alternative model for the helping relationship is termed the “ministry model” (Adelman & Frey, 1997), “social work model” (Meyerson 1994, 1998), “reflective practitioner model” (Moroney et al., 1998; Schön, 1983), and the “patient-centered” approach (Levenstein, McCracken, McWhinney, Stewart, & Brown, 1986). Although some of these models are associated with a particular human service occupation, with, for instance, both the professional agency model and social work model based on the social work profession, these models provide a conceptual scheme that is critical for understanding different approaches to the care relationship. Specifically, these models differ along two major dimensions: (1) the distribution and exercise of control in the care-provider and care-recipient relationship, and (2) the amount of emotional connection and emotional expression between the care provider and care recipient.

The distribution and exercise of control are central communicative concerns in the helping relationship. Within the professional agency model, care providers take the expert and assertive role, whereas care recipients act in the dependent and passive role (Morgan & Krone, 2001; Moroney et al., 1998; Thompson & Parrott, 2002; Walker et al., 2001). Organizational and institutional discourse where this type of relationship dominates tends to define clients and care recipients as “passive recipients of pre-defined services” (Tretheway, 1997, p. 28). Particularly in the medical arena, clients may come to expect this type of asymmetrical care relationship and may be upset when the dominant role is not enacted by
care providers (Morgan & Krone, 2001). In contrast, the reflective practitioner model calls for a more symmetrical relationship in which care providers and recipients share control and work together to make decisions. In this model, both participants are expected to take an active role in determining the appropriate provision of care.

The second major difference between the professional agency model and the reflective practitioner model concerns the role of emotions on the part of care providers. Within the professional agency model, care providers are expected to remain emotionally detached, privileging rational decision making over emotional expression. Proponents of this model argue that such detachment protects care providers from stress and burnout (Lief & Fox, 1963). Historically, care providers have been socialized to exhibit this type of professional demeanor in the workplace, leading recipients to expect that demeanor. For example, Morgan and Krone’s (2001) examination of emotional expression within a cardiac care center found that patients reacted negatively when physicians strayed from strict rationality and certainty when offering a diagnosis. As Morgan and Krone concluded, “Patients may expect doctors to exhibit certainty to quiet their own emotional turmoil stirring below the surface. To do this, patients unwittingly guide physician performances of emotion toward the rationality norms they have come to expect from medical personnel” (p. 331). Such expectations on the part of some care recipients reinforce the professional agency model by ensuring the maintenance of strict, professional boundaries (Adelman & Frey, 1997).

The reflective practitioner model, in contrast, questions the lack of emotional connection between care providers and recipients that characterizes the professional agency model. In therapeutic communication, one of the earliest proponents of this type of care relationship was Carl Rogers, who developed the concept of “person-centered therapy” (see Rogers, 1977). Within this alternative model, care providers are encouraged to emphasize love, support, and close relationships with recipients (Adelman & Frey, 1997; Karabanow, 1999; Tuominen, 2000). Tim McCormick, Chief Executive Officer of a residential facility for persons with AIDS, described his commitment to the reflective practitioner model:

> Are we in this mode of boundaries of social service delivery, which is good for a social service agency, or are we in a ministerial mode that says...love is unconditional and really knows no boundaries? Our mission statement is compassion and hope. (Adelman & Frey, 1997, p. 68)

Although care providers operating from this model connect emotionally with recipients because it fits better with their ideology of care, they also report boundary struggles within their caring relationships (Hullett, McMillan, & Rogan, 2000; Stone, 2000; Ungerson, 2000). Consequently, caregivers can become emotionally connected with clients or patients in ways that can lead to emotional distress and burnout (Miller, Stiff, & Ellis, 1988).

The juxtaposition of these two models problematizes several primary issues regarding communication and care in helping relationships. Rarely do helping relationships exist purely within one of these models; more commonly, providers and recipients must negotiate control, manage boundaries, create rules for emotional expression, and exchange information. In doing so, care providers and recipients make choices about the helping relationship created, and each choice entails a set of consequences for both parties. In the next section, we consider research that explores the variety of communication choices encountered in the helping relationship and the subsequent impact of those choices on care providers and recipients.
Research has examined choices regarding both the content and processes of communication. We first examine the content of communication in the helping professions and then discuss the processes through which this content might be most “helpfully” communicated.

Content of Communication

One of the most fundamental content areas of communication in helping relationships is the exchange of information between care recipients and providers (Hullett et al., 2000). Often, care providers have specialized expert information that helps care recipients to understand their situation and make choices. For example, patients expect their physicians to give them information about diagnosis and treatment (Thompson & Parrott, 2002; see also Kreps & Bonaguro, this volume). Care providers also offer information about negotiating the complex bureaucratic systems within which care recipients function. Tretheway (1997) found that participants in a welfare program cited their social workers’ provision of information about services and advice on ways to navigate the “system” to be among the social workers’ most valuable and caring skills. In their study of compassionate communication, Miller (2007) argued that information itself constituted compassion in many instances. A priest...said that, often, compassion consisted of “providing someone with correct information”; a child abuse counselor...talked about compassion as involving the education of parents; and a prison chaplain...described the bittersweet experience of providing information about the location of a body to a victim's family as compassionate. (p. 234)

Although care providers may deliver positive information to care recipients, often, like prison chaplains, they are compelled to communicate negative information. The delivery of bad news, an “intervention that produces a negative alteration to a person’s expectations about their [sic] present and future” (Fallowfield & Jenkins, 2004, p. 312), has been a focus of considerable communication research (for extensive reviews of this literature, see Fallowfield & Jenkins, 2004; Gillotti, Thompson, & McNeilis, 2002). When delivering bad news, it is especially important that care providers express care and concern rather than convey the negative information in a cold and detached manner (Fallowfield & Jenkins, 2004).

In addition to providing informational support, care providers also offer emotional support to recipients. The communication of emotional support by care providers consistently is related to positive care-recipient outcomes, such as satisfaction and improved social or physical condition (Fallowfield & Jenkins, 2004; Karabanow, 1999; Sass, 2000; Sass & Mattson, 1999). Emotional support may take the form of coaching, providing encouragement, calming fears, or simply listening to care recipients (Karabanow, 1999; Nunnally & Moy, 1989). In a study of nursing home caregivers, Sass (2000) found that care providers regularly engaged in “courtesies” that involved complimenting, congratulating, encouraging, and comforting residents. As the following story illustrates, these courtesies provide positive emotional support for recipients:

Upon reaching the Medicare wing, I saw Edna sitting in her wheelchair in the hallway near the nurses’ station. Often uneasy and vocal, today she was much more quiet than usual. Bruce, a lay chaplain who was visiting residents on this wing, noticed her and approached her. He bent over from the side, put his hands on the arm of
her wheelchair and began to inquire about how she was. She told him that she was very nervous today. He began a conversation of quiet questioning and reassurance. Although I chose not to hear the content of the conversation, I could see that she was responding positively. I can’t recall another time when Edna appeared so peaceful. (Sass, 2000, p. 341)

The content of caring communication may involve establishing boundaries that protect the interests of both care providers and recipients (Hepworth, 1993; Sass & Mattson, 1999; Tretheway, 1997; Tuominen, 2000; Ungerson, 2000). These boundaries might be established by specifying rules for interaction or by redirecting conversation when it is straying into areas that might make either the care provider or recipient feel vulnerable (Ungerson, 2000). Thus, as argued by the professional agency model, providers need to take care to keep their relationship with recipients professional and be wary of blurring the line between professional relationship and friendship. Tuominen (2000) found a similar need for boundary maintenance in her study of relationships between daycare providers and parents. As Julie, a family child-care provider of 15 years, stated, “It’s rough. But you do learn that at some point, even though you feel bad, parents still have to be responsible for those kids. And you have to learn to turn it off. But it’s hard sometimes” (Tuominen, p. 123).

Establishing boundaries may be especially important with care recipients who exhibit manipulative behavior in the helping relationship. Hepworth (1993) suggested that clients may try to manipulate care providers to control treatment options that are offered, gratify needs and desires that are not sufficiently obtained from other relationships, or avoid aversive consequences of irresponsible behavior. Because clients may engage in such strategies, which, in many cases, can subvert their healing, it is important that care providers establish and maintain some control over the communication that occurs in the helping relationship.

To accomplish this task, care providers may engage in supportive communication that holds care recipients accountable and works to gain their compliance with organizational and institutional rules or treatment plans. Sass and Mattson (1999) examined such uncomfortable social support in their ethnographic study of an at-risk youth shelter, and found that confrontational communication often was a valuable form of support. Sass and Mattson noted how this type of support was enacted in an interchange between a youth and a counselor at a retreat:

Under the direction of a loud and forceful adult, each youth had to answer the questions, “What is your act? And how is that act destroying your life?” The “act” of one youth involved a strong affinity for marijuana. This was met by a tirade from the course leader. “You’ve sold your life to get high. That’s what you are. You’re a pothead.” ... Through this episode of confrontation, the leader supported the youth in his commitment to making a difference in his own life. (p. 530)

In sum, the content of care providers’ communication in helping relationships is both informational and emotionally supportive, and may be both positively and negatively valenced. Challenges arise for care providers when making choices about how to balance these various types of communication content.

Process of Communication

In addition to considering communication content, researchers also have focused on communication processes in helping relationships. Two main themes emerge for care...
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providers from this literature: the importance of perspective taking and the management of nonverbal elements of communication.

To communicate support appropriately, it is vital that care providers engage in perspective taking to understand the needs and concerns of care recipients (Bailey & Wilkinson, 1998; Nunnally & Moy, 1989; Sparks, Villagran, Parker-Raley, & Cunningham, 2007; Walker et al., 2001; Wiman & Wikblad, 2004). Care recipients report that effective provider communication encompasses the basic communication skills that allow for perspective taking, including listening, asking simple questions, being clear and articulate, speaking loudly, and maintaining eye contact (Bailey & Wilkinson, 1998; Nunnally & Moy, 1989). In their study of provider–patient relationships in a family practice clinic, Walker et al. (2001) found that perspective taking by providers was particularly important in the early stages of a caring relationship when care recipients test the trustworthiness of care providers. They suggested that care providers can exhibit trustworthiness by being sensitive to care recipients’ nonverbal cues, appreciating recipients’ uniqueness, engaging in verbal expressions of positive regard, and being active listeners.

As the relationship between care providers and recipients develops, providers must continue to engage in perspective taking. In their study of occupational therapy interactions, Mattsson and den Haring (1999) found that care providers often responded initially to clients’ negative statements with positive motivating statements. In subsequent client interviews, however, they found that moving directly to motivational statements without determining why clients have a negative reaction in the first place can have a negative impact on both the therapist–client relationship and treatment outcomes. These studies underscore the importance of perspective taking by providers for engaging in caring communication in helping relationships.

Care recipients also expect care providers to pay careful attention to nonverbal factors in interaction. Touch, for instance, is one of the most common expressions of nonverbal care in the helping relationship (Miller, 2007; Morgan & Krone, 2001; Sass, 2000). Because care providers’ work with recipients may involve touch, the manner in which touch is used can be particularly expressive. Caring touch might include holding a hand during surgery (Morgan & Krone, 2001) or the exchange of a hug on a care recipient’s birthday (Sass, 2000).

The therapeutic environment also is a central nonverbal element of helping relationships, and, consequently, care providers often structure the care environment to meet the needs of their clients. This structuring of the environment may be something as simple as finding a private room when giving clients bad news (Walker et al., 2001) or providing a separate waiting area for patients with fertility issues in an obstetrician’s office (Miller, 2007). Care recipients’ environments also may be a source of information for care providers. Family pictures and mementos, for example, might provide valuable information about a care recipient’s social system or values. As a hospital chaplain explained:

It’s amazing what you can see when you walk into a patient’s room…. What I hope some of us who are in this business have done is to train our natural eye that sees those things anyway to be more acute and to see them more purposefully. (Miller, 2007, p. 231)

The third major nonverbal element of providers’ caring communication is simply spending time with care recipients. Walker et al. (2001) found that recipients often equate time spent with care. Although care recipients equated quality care with extended time spent in interaction, care providers believed that quality care could be given in a shorter amount of time. The importance of time spent with care recipients may vary depending
on the type of care provider. For example, nurses report wanting more time to communicate with patients, but physicians tend to overestimate the amount of time they spend with patients and believe that quality of time is more important than quantity of time (Thompson & Parrott, 2002). Spending time becomes especially important for care recipients when the content of the communication involves bad news, as recipients often want time to process the bad news before being immediately overloaded with more specific information, such as treatment options (Gillotti et al., 2002).

As evidenced by this review, communication processes in helping relationships are complicated and difficult, requiring intense awareness, skill, and dexterity on the part of care providers. In short, care providers engage in strenuous emotional, and sometimes physical, labor as they help their clients. In the next section, we examine the outcomes of this emotional labor for care providers and explore both the positive and negative consequences of helping.

**Care-Provider Outcomes**

Hochschild (1983) introduced the concept of *emotional labor* to refer to occupations in which employees are expected to display certain emotions to satisfy occupational goals, and the helping professions certainly fall into this category. In addition, helping professionals may encounter particularly demanding performance expectations as they strive to live up to their personal emotional expectations in addition to professional and organizational expectations (Meyerson, 1994; Mumby & Putnam, 1992).

In care settings, implicit and explicit rules dictate how care providers should manage and display their emotions. The most frequent emotion rule, particularly within the medical model, demands that care providers carefully manage their emotions and remain emotionally detached from care recipients (Adelman & Frey, 1997; Hafferty, 1988; Morgan & Krone, 2001). Although caregivers, according to this model, are expected to remain inwardly detached, outwardly, they are expected, by themselves, supervisors, and clients, to express care, sympathy, and empathy (Hullett et al., 2000; Karabanow, 1999; Stone, 2000; S. J. Tracy & Tracy, 1998).

Helping professionals often experience these emotions spontaneously as a natural result of performing organizational tasks (Mumby & Putnam, 1992). In other cases, employees may “force” an outward emotional expression in accordance with emotion rules without actually feeling that emotion at a deep level (Hochschild, 1983). In both situations, helping professionals can experience stress, as the display of unfelt emotion can produce emotional dissonance and the spontaneous expression of emotion can lead to attachments to clients that could create emotional distress.

Both types of emotional expression (spontaneous and manufactured) may be positively or negatively valenced, and providers may experience positive and negative emotions simultaneously as they interact with care recipients, coworkers, and supervisors. As noted earlier, many people enter caring careers because they feel called to do so or because caring is an important part of their personality; hence, caring interactions make them feel a sense of joy, fulfillment, and personal accomplishment (Ebenstein, 1998; Hullett et al., 2000; Tuominen, 2000). Some care providers, particularly those outside of traditional organizational and institutional settings, cite creativity, flexibility, and autonomy as further benefits (Tuominen, 2000). However, the caring professions also can be a site of negative emotions as care providers share the sadness of care recipients’ situations or experience anger at structural constraints or at requirements of their organization that seem to compromise their provision of care (Copp, 1998; Karabanow, 1999). Furthermore, care providers sometimes need to cope with recipients’ negative emotions, such as
anger and associated aggression. For example, Goodridge et al. (1996) reported on the stress experienced by nursing assistants in a long-term care facility when their elderly patients were aggressive and abusive.

A large body of research literature has considered the negative effects of working in caring professions, with particular focus on the problems of vicarious traumatization (Beaton & Murphy, 1995; Sexton, 1999) and burnout (Albrecht, Irey, & Mundy, 1982; Coady, Kent, & Davis, 1990; Copp, 1998; Ellis & Miller, 1993; Evers & Tomic, 2003; Holm, 2002; Leiter & Maslach, 1988; Maslach, 1982; Meyerson, 1994; Miller, Birkholt, Scott, & Stage, 1995; Miller, Stiff, & Ellis, 1988; Miller, Zook, & Ellis, 1989; Pines & Kafry, 1978; Ray & Miller, 1991; Starnaman & Miller, 1992; Um & Harrison, 1998; Zhang & Zhu, 2008).

Vicarious traumatization occurs when care providers begin to take on their clients’ emotions, particularly after the client has a traumatic experience (Sexton, 1999). Doing so may make care providers more susceptible to burnout, characterized by emotional exhaustion, depersonalization, and decreased feelings of personal accomplishment (Maslach, 1982). Emotional exhaustion leads to feeling fatigued and an inability to deal with the emotional stress at work; depersonalization is recognized by a change in perspective in which care providers begin to detach from and see their clients as deserving of their problems. Helping professionals also may experience decreased feelings of personal accomplishment and start to feel as if they are incapable of making a difference.

Burnout has been attributed to a variety of organizational and personal stressors. Most commonly, burnout is attributed to job factors, such as workload, role conflict, and role ambiguity (e.g., Evers & Tomic, 2003; Lloyd, King, & Chenoweth, 2002; Miller, Ellis, Zook, & Lyles, 1990). Lloyd et al. (2002) also suggested that personal predispositions may increase burnout, as individuals who select human service careers may have higher predilections toward stress and anxiety than other people (see also Avtgis & Rancer, 2008; Teven, 2007).

The high emotional demands of most caring careers also contribute to burnout. For instance, E. Tracy and Bean’s (1992) survey of 36 child welfare caseworkers showed that job stress and subsequent burnout were caused by the emotional impact of seeing clients’ difficult living conditions, working with severely abused children, recommending removal of a child from the home, and working in high crime areas and bad weather conditions. In addition, dealing intensely with clients over limited time periods proved exhausting emotionally. A similar relationship between emotional demand and burnout was found in a study of oncology care providers, which showed that confrontation with death and dying led to significant emotional exhaustion, particularly in care providers who were more susceptible to emotional contagion (LeBlanc, Bakker, Peeters, van Heesch, & Schaufeli, 2001).

The manner in which caregivers manage their emotional connection with clients plays a central role in their propensity for burnout. Miller et al. (1988) explored the relationship between communication, emotions, and burnout, developing a model that has been verified and tested in research with human service workers (Miller et al., 1995). Miller and colleagues proposed that care providers may experience two types of empathy in caring interactions, each of which has an impact on how providers respond to clients and, ultimately, on providers’ burnout: (1) Emotional contagion is an affective response in which care providers experience emotions parallel to that of care recipients and (2) empathic concern is an affective response in which providers care for clients but do not experience emotions parallel to clients. Whereas empathic concern increases care providers’ abilities to communicate effectively with recipients, emotional contagion increases providers’ emotional exhaustion, impairs their ability to communicatively respond to
clients’ needs, and subsequently increases burnout for providers (Miller, Birkholt et al., 1995; Miller et al., 1988).

The management of emotions becomes particularly important given the serious consequences that burnout carries for care providers. In a study of the impact of providers’ burnout on their family relationships, Jayaratne, Chess, and Kunkel (1986) found that social workers experiencing burnout also experienced increased depression, anxiety, and irritableness, along with lower marital satisfaction. In addition to these psychological problems, burnout can lead to physical problems for providers, including coronary heart disease (House & Cottington, 1986) and high blood pressure (Fox, Dwyer, & Ganster, 1993). Provider burnout also has serious consequences for organizations; for example, Mor Barak, Nissly, and Levin (2001) reported that turnover rates among social service professionals may be as high as 60% in a typical year, with burnout being a leading cause. Burnout also can lead to decreased morale, increased absenteeism, and impaired performance (Maslach, 1982).

The Context of the Helping Professions

To this point, we have looked at the helping relationship at an interpersonal level by considering key aspects of interaction between care providers and care recipients. In the final section of this chapter, we put this interpersonal relationship into the context in which helping professionals work and communicate. Our consideration of contextual issues takes a “levels” approach, beginning with a look at communication in group and team contexts and then moving to an examination of the organizational and health-care systems level. In each of these areas, our discussion is illustrative rather than comprehensive. We consider some of the key issues that are critical for understanding the context in which helping professionals do their jobs, and we point readers to more comprehensive reviews of relevant literature. We close the chapter with a discussion of several overarching questions that could guide future applied communication research regarding communication and the helping professions.

Helping Professionals in the Group/Team Context

Especially in today’s society, in which needs for help often are complex and multifaceted, a great deal of the work of those in the helping professions takes place in groups or teams. Although some helping professions still involve a fair amount of individual work (e.g., ministry and some counseling professions), for many other helping professionals—especially those in health-care settings—the work typically involves interaction with a wide array of other professionals. In a recent review of communication in health care groups and teams, Poole and Real (2003) provided a useful framework for consideration of the team context, noting that health-care professionals work in team settings involving single or multiple disciplines, and varying levels of interdependency among team members. These teams also vary in their permanence, structure, and openness to the larger organizational and institutional context. For example, a group of nurses and nurse assistants working on a hospital’s medical surgical floor represents a relatively homogeneous professional group that can remain relatively steady over time; in contrast, a team in a geriatric rehabilitation unit likely consists of a wide array of helping professions, including physicians, nurses, physical and occupational therapists, social workers, and dieticians.

Poole and Real (2003) pointed out a number of weaknesses in research on groups and teams in the health-care setting. For example, a great deal of the research is anecdotal, and there is little definitive evidence regarding outcomes—especially outcomes for
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patients or clients. Furthermore, much of the research in this area shortchanges a consideration of communication processes and, over time, of group development. However, from the perspective of individuals within the helping professions, it is possible to identify several conclusions regarding ways in which the group/team context influences work and communication.

First, it is clear from the extant research that the values of various helping professions present both important opportunities and critical challenges for care delivery. Obviously, as the needs of clients become more complex, it is important to pull together interdisciplinary teams to address the multiple issues involved. Interdisciplinary teams especially are prevalent—and can be particularly effective—in complex client systems, such as geriatric care (e.g., Hogan & Fox, 1990), mental health (e.g., Alexander, Lichtenstein, Jinnett, D'Aunno, & Ullman, 1996), and social work (e.g., Abramson & Mizrahi, 1996). For example, Mohr, Curran, Coutts, and Dennis (2002) pointed to the need for interdisciplinary collaboration when providing services for clients who suffer from both mental illness and intellectual disability, and Okamoto (2001), in a study of treating high-risk youth, argued that “interagency collaboration is considered an essential component toward effectively serving difficult, multi-problem adolescents” (p. 6). However, as representatives of various helping professions come together on these teams, they bring with them very different values that can lead to conflict and require negotiation among team members. Abramson (1993), for instance, pointed to the very different perspectives often taken by social workers and medical professionals, as social workers’ training in a systemic and community-based view of working with clients can clash with the clinical perspective adopted more often by medical professionals.

These differences in professional orientation become particularly pronounced when the issue of professional power is considered. In a classic study of interdisciplinary teamwork, Banta and Fox (1972) examined the work of a health-care team in a poverty community. Members of the interdisciplinary team—physicians, public health nurses, and social workers—brought with them very different philosophies about the cycle of poverty and how it could be broken and about how best to interact with clients. Furthermore, differences in members’ education and specialized training imbued these contrasting philosophies and orientations toward care. In this case, and in many other examples of interdisciplinary care teams, there is the presumption that physicians ultimately are in control, although other members of the team (e.g., social workers or nurses) may better understand the complex needs of clients or patients. However, even when efforts are made to equalize power in interdisciplinary helping groups, the power of professional status often reasserts itself over time (Feiger & Schmitt, 1979).

Finally, the group context in which helping professionals work involves more than just interactions between members of the care group and clients. Putnam and Stohl (1990, 1996) highlighted the importance of considering “bona fide groups” that demonstrate permeable boundaries and are interdependent with their relevant contexts. This call is particularly apropos for a consideration of groups in helping contexts, as these teams are especially fluid in their membership and are highly interdependent with the organizational and institutional context. Several studies of communication in the helping professions have taken the notion of bona fide groups to heart. For example, Bertetti and Seibold (1994) demonstrated the importance of negotiating shifting boundaries, goals, and membership within hospice teams, and Lammers and Krikorian (1997) argued that a bona fide group perspective is necessary to understand the fluid, active, and goal-directed activities of surgical teams. Ellingson (2003) also extended the bona fide group perspective in her study of communication among members of a geriatric oncology team, contending that some of the most critical communication among team members occurs
“backstage” as helping professionals on these teams share information, check on the clinical progress of clients, handle the formal and informal needs of the team, and build relationships among team members.

**Helping Professionals in the Organizational Context**

In addition to the group context in which helping professionals interact, it is critical to consider the organizational contexts in which human service workers are embedded. Scholars in organizational communication and related fields have long considered the nature and effects of organizational “culture” (for a review, see Eisenberg & Riley, 2001), arguing that organizations can be characterized in terms of values, beliefs, norms, stories, and ongoing patterns of interaction (see also Seibold, Lemus, Ballard, and Myers, this volume). Organizational culture is not a static entity but emerges through organizational interaction in ways that might be fragmented, contradictory, and contested. Clearly, the organizational cultures and subcultures in which human service professionals interact can vary greatly, and these various cultures can have important effects on how individuals feel about their jobs and how they interact with clients.

At the most basic level, the “relational” distinctions we made in the last section of this chapter regarding communication with clients can be expanded to the organizational level. We previously considered two models of care: the professional agency model and the reflective practitioner model. At the relational level, these models define the roles of practitioner and client, and the role of emotion in caregiving interaction. The distinctions made here at the relational level can be usefully raised to the organizational level, as demonstrated in Meyerson’s (1994, 1998) studies of social work professionals based in hospitals with very different cultures. In one hospital (which she labeled as following the medical model), the problems of patients largely were seen in terms of individual pathology; in the other hospital (which she labeled as following the social work model), the problems of patients were considered in a more systemic way that focused on a wider range of psychosocial issues (e.g., family structure, relationships, and community resources). Most interesting was Meyerson’s discussion of ways in which these models for treating patients were reflected in relationships among organizational members. Specifically, helping professionals in the social work culture were much more likely than those in the medical model culture to accept the inevitability of stress in the ambiguous context of care provision and to work effectively in the midst of this ambiguity and stress. As Meyerson (1994) summarized, “Although these social workers joked openly about the level of chaos and lack of control, they spoke enthusiastically about the unit’s effectiveness” (p. 646). In contrast, stress and ambiguity were seen as pathologies in the other hospital; as Meyerson (1994) noted, “social workers in [this hospital]...tended to interpret burnout as a disease of the individual” (p. 643).

Other scholars also have noted the importance of the organization, both in defining stress and in providing support for workers in the helping professions. For example, Miller (1998) considered ways in which leaders in a nursing department created tension through an emphasis on the importance of constant change and chaos in the hospital environment. These nurses lived “on the edge of chaos,” which fostered both innovation (the desired outcome) and intense stress (the unintended consequence). Karabanow (1999) considered ways in which organizational leadership and culture defined appropriate relationships with clients for social workers in a street kid agency, and Kahn (1993) looked at the ongoing stresses of human service work and ways in which coworkers were both successful and unsuccessful in “caring for the caregivers.” More generally, Apker and Ray (2003) provided a comprehensive review of stress and social support processes.
in health-care organizations that are applicable to a wide range of human service organizations. Their review identified a variety of organizational sources of stress for human service workers (e.g., load, role stress, and emotional labor) and that the most potent forms of support often come from others within the organizational context (see, e.g., Ellis & Miller, 1993; Ray & Miller, 1990, 1994), as organizational “insiders” often are most knowledgeable both about the sources of stress and the most efficacious ways to deal with stress. This organizational support can come through formal programs (e.g., Thomas & Ganster, 1995), but is more likely to involve emotional, informational, and instrumental support from coworkers, supervisors, and subordinates.

**Helping Professionals in Systems Contexts**

Finally, we consider the larger institutional contexts in which human service professionals work. We could consider a number of issues with regard to the systems context of health and helping institutions, including issues of government and legislative control, media influence, interorganizational relationships, or the influence of national and ethnic culture. A consideration of these myriad issues that influence the practice of human service work is beyond the scope of this chapter; consequently, we concentrate on raising issues with regard to what many human service workers see as a critical defining feature of their work at the beginning of the 21st century: the challenges of working within a managed care environment.

Although there often is a great deal of conceptual disagreement regarding the meaning of “managed care” (Hacker & Marmor, 1999), most scholars agree that managed care is a philosophy and system of health and human service delivery in which care delivery and cost control explicitly are intertwined through the interaction of insurers, providers, and patients. Managed care systems attempt to balance the often contradictory goals of access, quality care, and cost containment (Miller & Ryan, 2001). Although managed care systems—and related organizational forms, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs)—have existed since the early part of the 20th century, these systems have become much more prevalent in the last 30 years and now are intimately tied to larger systems of funding in health and human services, such as Medicaid and Medicare. In emphasizing the simultaneous goals of care quality and cost containment, managed care systems often introduce specific organizational and communication processes, such as gatekeeping through primary care providers, clinical effectiveness research, risk adjustment, utilization review before the approval of particular therapies or procedures, case management, interdisciplinary teams, and an emphasis on preventive therapies.

There has been a great deal of speculation regarding the effects of managed care on members of the helping profession, but limited empirical research. For example, O’Neil and Finocchio (1997) painted a rosy future for physicians, nurses, and allied health workers if members of these professions just embraced the challenges and opportunities presented by managed care. However, such rosy prognostications have been the exception (e.g., Waitzkin & Fishman, 1997). In the communication discipline, Lammers and Geist (1997) pointed to the possible negative impact of managed care on caring in helping organizations, arguing that managed care transforms patients from sufferers into consumers, turning organizations into factories, patients and clients from individuals deserving of care into members of populations requiring cost control, and providers into bureaucrats. In short, managed care is seen as a system in which the humanity of both clients and professionals are stripped away as the needs of corporate payors take precedence in the helping relationship.
In the years since these predictions regarding both the light and shadow of managed care (Lammers & Geist, 1997), some research has been conducted that provides insight into how members of the helping professions work in the context of these institutional systems. For example, Lammers and Duggan (2002) reported that physicians felt dissatisfied with their managed care experiences, although it appeared that managed care was only one of many factors contributing to their concerns about communication with clients (Miller, 2002) and that physicians’ institutional beliefs may moderate the negative relationship between managed care medical practice and satisfaction (Barbour & Lammers, 2007). For the nursing profession, Miller, Apker, and colleagues (Apker, 2001; Miller & Apker, 2002; Miller, Joseph, & Apker, 2000) have conducted research about ways in which roles sometimes must be reconfigured as managed care systems take precedence in health care. For example, Miller and Apker (2002) argued that nurses often must move from their traditional role sets of offering “empathy and education” into areas such as collaboration, change management, and conflict resolution. The social work profession also is grappling with changes in practice in the managed care context. Keigher (2000) pointed to the heightened importance of “case management” in recent years, noting that social workers can be central members of case management systems in managed care because of the profession’s traditional emphasis on the interdependence of care professionals and the importance of helping within the community system. However, others have noted that the enhanced interdependence required by managed care systems (and made possible through advanced computer and communication technologies; see Kreps & Bonaguro, this volume; Lievrouw, this volume) raises important concerns about patient and client confidentiality. As Rock and Congress (1999) explained, “When a managed care company is involved, as many as 17 people may know about the client’s treatment” (p. 256).

This research points to some of the challenges faced by helping professionals in the “age of managed care.” As payment becomes more intimately connected to care, helping professionals find themselves in uncomfortable roles involving business management and the allocation of care in an environment of limited resources. The helping relationship is less buffered from the larger environment than previously, which influences both the provision of care and the way that care providers feel about the work they do. However, managed care also offers opportunities for helping professionals, such as enhanced attention to continuity of care, increased interdependence with care providers in a variety of disciplines, and a renewed emphasis on systems of prevention rather than just systems of treatment. The future will reveal the extent to which it is possible to maintain quality relationships between care providers and recipients—and enhance outcomes for both—and cope with increased pressure for efficiency and economic viability.

Conclusion

This chapter has pointed to the complexity of communication processes for those working in the helping professions. Care providers—motivated by compassion, altruism, and a desire for interaction with others—are socialized into professions, organizations, and institutions that emphasize technical skills but often shortchange communication competencies. In relationships with clients, members of the helping professions engage in interaction that requires attention to both the instrumental and emotional needs of clients. This interaction often is intense and can lead to stress and burnout, but also immense personal satisfaction. Moreover, interactions between clients and professionals are embedded within care teams, organizational cultures, and institutional systems. These contexts add complexity to the experience of helping professionals, including concerns
with interdisciplinary cooperation, social support for coworkers, role development, and confidentiality.

This review of the relevant literature regarding communication in the helping professions demonstrates both what we know and areas in which applied communication researchers can contribute in the future. Clearly, applied communication researchers can contribute most directly to understanding interactions between care providers and care recipients, such as how care can be provided in ways that offer both instrumental and emotional care for the client and that buffer the care provider from the insidious problem of burnout, how helping professionals can use verbal and nonverbal channels to balance clients’ need for both information and emotional support, and, perhaps most important, how training programs can be structured to enhance the quality of communication in the helping professions and preserve the empathy and altruism that motivate many people to enter the helping professions in the first place.

Applied communication scholars, however, also can take a leading role in investigating the role of context in the communication of helping professionals. This focus is especially significant given contemporary societal changes—including the aging of the U.S. population, increasing chronicity of disease, and decreasing role of the extended family in care provision—that point to the increasing importance of helping professionals. Applied communication scholars are well positioned to investigate not just interactions between care providers and clients but to consider the complex patterns of communication among teams of helping professionals. Furthermore, researchers can apply an understanding of communication culture to human service workplaces. Finally, applied communication scholars can consider the nuances of the now-dominant managed care environment and explore ways in which human service professionals can effectively cope with—or perhaps challenge—managed care systems.

Taking advantage of these research opportunities will continue to reinforce the value of applied communication scholarship in today’s complex and shifting society. Applied communication scholarship should make a difference to people in need, and there is no area in which our scholarly resources can be better deployed than that of assisting practitioners engaged in helping others to do their work in ways that are more professionally productive and personally rewarding.

References


