

**Dying Professions:
Exploring Emotion Management Among Doctors and Funeral Directors**

by

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ABSTRACT *There are few more emotive experiences in life than death. Drawing on Arlie Hochschild's concept of emotional labour, this study compares the emotional responsibilities of two groups of death professionals: doctors and funeral directors. This study addresses the lack of comparative studies in the otherwise robust literature concerning emotional labour in the workforce. Through qualitative analysis, I identify how funeral directors and doctors believe they should feel in regards to death, how they manage these feelings, and the related consequences of this emotional labour. Due to their unique position of encountering death as part of a job, death professionals have much to teach each other, as well as the broader population, about accepting and managing emotions related to mortality.*

Keywords: Emotional Labour, Death Attitudes, Emotion Management, Surface Acting, Deep Acting

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INTRODUCTION

Akin to death, emotions are inseparable from the human experience (Glomb & Tews, 2004). Our worldviews are discovered and derived from feeling (Hochschild, 1983). Studying emotional experience in the workplace sheds light on the social-psychological processes related to wellbeing in the modern North American economy and society as a whole (Wharton, 2009). Further, emotion management studies can help craft effective interventions to prevent the negative consequences associated with emotional labour (Bianchi et al., 2014; Hochschild, 1983). With these thoughts in mind, my thesis is framed by the following question: How do frequent workplace encounters with death shape the emotion management of doctors and funeral directors?

These professions encounter death from unique perspectives. In crude terms, for doctors, death is loss, whereas for funeral directors, it is gain. Doctors are committed to the healing process and in many fields of medicine dying patients threaten their defined role, leading to feelings of failure and inadequacy (Auger, 2000; Palgi & Abramovitch, 1984; Strazzari, 2005). In contrast, for funeral directors death signifies business; it is both expected and relied upon. These contrasting perspectives may shape how doctors and funeral directors conceptualize death, which could in turn affect how they form their emotion management strategies. Thus, strategies from one profession may provide insight into skills that could be used by the other.

Through exploration of day-to-day emotion management strategies and death attitudes of funeral directors and doctors, I identify the tacit rules that dictate how funeral directors and doctors should respectively feel in regards to death. I will discuss three broad themes that arose from my findings: emotional labour in professional death

experiences; the feeling rules that govern this emotional labour; and the related consequences of this emotional labour. This study is grounded in two key areas of literature, emotional labour and contemporary North American death attitudes, which I now explore in greater detail.

THEORETICAL FRAMEWORK: Managing Emotions & Denying Death in North America

Emotional Labour in the Workplace

Emotions help anchor one's sense of self, and act as a signal function; that is, they provide 'feeling clues' that give individuals an idea of how to respond to a given situation (Hochschild, 1983). For instance, if one feels frightened, this signals one to enact an appropriate response such as screaming, leaving or hiding. An organismic model of emotion argues that this emotional response is biological and innate (Ekman, 1982; Hochschild, 1983). However, a purely instinctual view of emotion fails to explain how people come to assess, label, and manage emotions (Ekman, 1982). Hochschild's (1983) definition of emotion, to which this study is most loyal, urges us to acknowledge the reflexive quality of emotions, arguing that the act of managing emotion is also a part of what the emotion becomes. This is supported by Thoits (1989), who asserts that the key determinants of emotional experience are sociocultural rather than biologically innate. The social nature of emotional responses has been well studied in anthropology, with evidence of cross-cultural variability in both emotions and emotional expression (Ekman, 1982; Peterson, 2004; Thoits, 1989).

Emotion management is the act of inducing or suppressing feeling in order to sustain the socially accepted and expected emotional response (Hochschild, 1983). In an applied context, this can be recognized as "acts upon feeling"; for example, *trying* to fall

in love, *letting* yourself feel sad, or *keeping* your anger in check (Hochschild, 1983, p.13). Emotional labour more specifically highlights the laborious nature of this management; it does not come naturally, it is emotion *work*. In the workplace, emotional labour speaks to the processes by which one must manage one's feelings in accordance with organizational rules and expectations (Hochschild, 1983; Wharton, 2009). It underlines the fact that emotions are not only shaped by cultural norms, they are increasingly regulated and shaped by employers (Wharton, 2009). Although this study refers to emotional labour in the workplace, emotional labour is also applicable to emotion work in other spheres, for instance, the gendered division of emotional labour in home life. For instance, women have traditionally been expected to undertake a greater proportion of "emotional" tasks and responsibilities, such as childcare (Hochschild, 1983; Peterson, 2004).

Emotional labour is informed and regulated by feeling rules (Hochschild, 1983). Feeling rules address the proper extent, direction and duration of a feeling in a given situation (Hochschild, 1979; Wharton, 2009). This refers to the notion that one can feel too much or too little, one can feel happy when one should feel sad and one can feel sad for too long, respectively. Feeling rules are recognized most easily when one is acting against them or in other words, when what one feels does not match what 'should' be felt (Hochschild, 1983).

In order to adhere to these feeling rules, people make use of a variety of emotion management strategies. For Hochschild (1983), two are of primary concern: surface acting and deep acting. Surface acting is a display of emotion with no internal change; it is convincing to others, but we have not deceived ourselves (Hochschild, 1983). Deep

acting involves a transformation of the actor's own emotions to fit the situation. It can involve directly exhorting feeling (e.g. psyching yourself up, 'you got this!') or retraining the imagination, akin to method acting (Hochschild, 1983). These two methods are theoretical in nature and are difficult for those using them to describe in explicit terms.

Concrete examples of emotion management strategies include use of humour (Hochschild, 1983; Smith & Kleinman, 1989; Mann, 2004; Lauder milk, 2012) or physical avoidance of emotionally laborious situations, such as the physical covering of a corpse's hands, face and genitalia (Smith & Kleinman, 1989; Auger, 2000; Lauder milk, 2012). Approaching death scientifically rather than emotionally is also prevalent in the medical profession (Hochschild, 1983; Smith & Kleinman, 1989). By competing for the highest grades, medical students develop the ability to separate feelings from class content, instead focusing on impersonal facts in the subject matter (Smith & Kleinman, 1989). These skills bring them more than academic success; they function as an emotion management mechanism as well. This scientific orientation may extend to funeral directors, as they are educated in mortuary science, thus also fluent in an objective, biomedical dialect.

One risk of emotional labour is that it "draws on a sense of self that we honor as deep and integral to our individuality" (Hochschild, 1983, p.7). When it is exploited, as it can be in the work setting, one can potentially become alienated from this vital part of oneself. The negative consequences of emotional labour are often a result of emotional dissonance, which occurs when the emotion one is expected to display is in direct opposition to what one feels on a personal level (Hochschild, 1983; Glomb & Tews, 2004; Wharton, 2009; Dijk & Brown, 2006). It can lead to a sense of self-estrangement

due to the deep connection between emotion and self-concept (Wharton, 2009). Workers who regularly display emotions that conflict with their true feelings are more likely to experience emotional exhaustion or burnout (Brotheridge & Grandey, 2002; Mann, 2004; Wharton, 2009; Dijk & Brown, 2006).

There is debate over whether emotional dissonance is a consequence of emotional labour (Wharton, 2009) or an inherent component of it (Dijk & Brown, 2006; Mann, 2004). Mann (2004) believes that genuinely felt emotions, such as those achieved through deep acting, do not qualify as emotional labour. This is supported by findings that link emotional dissonance with surface acting more than deep acting (Wharton, 2009).

Autonomy can offset the negative effects of emotional labour (Hochschild, 1983; Mann, 2004). Professionals who do not work with an “emotion supervisor” immediately at hand have the autonomy to regulate their own emotional behaviour (Hochschild, 1983; Smith & Kleinman, 1989). They are therefore considered “privileged emotion managers” (Wharton, 2009, p. 152).

Further, identifying with strongly with one’s social role can also serve as an anchor to offset the negative effects of emotional labour (Sloan, 2007; Goffman, 1959). Those with established social roles often feel more comfortable adhering to its associated feeling rules (Hochschild, 1983). Thus, rather than feeling alienated from the societal whole, embracing their occupational roles as integral parts of their identity may allow these professionals to both accept and embrace death in a way most cannot without suffering from emotional burnout.

Death Denial in North America

There are few more emotive experiences in North American life than death. Contemporary death attitudes are characterized by fear, guilt and death denial (Auger, 2000). This discomfort manifests as an avoidance of dying persons, avoidance of the bereaved, a fear of death and a feeling of uncertainty about an afterlife (Palgi & Abramovitch, 1984; Aries, 1974). As a result, the living are actively separated from the dead and death is met with ambivalence (Aries, 1982; Auger, 2000; Palgi & Abramovitch, 1984; Strazzari, 2005). This ambivalent attitude is reflected in the experience of simultaneous love for the dead person and fear of the corpse (Palgi & Abramovitch, 1984). Although this orientation towards death has been linked to the decline of religion and rise of secularism, secularism itself is not at fault; rather researchers blame this shift on the lack of a sufficient replacement for religion (Mellor & Shilling, 1993). Without a way to situate their mortality, for many death in the modern context has become confusing and isolating (Mellor & Shilling, 1993). Due to their routine professional relationship with death, funeral directors and doctors become exceptions to this rule and thus interesting cases to study in order to greater understand the societal taboos and attitudes towards death in the 21st century (Freud, 1955).

According to previous studies, death has replaced sex as the ultimate “unmentionable”, giving rise to a phenomenon Gorer (1955) has coined the “pornography of death.” This term is particularly useful as it not only implies death’s taboo status, it also captures the following nuance: prevalent media portrayals of death mean that the average American TV-viewing child will see 10,000 deaths by the time they reach age 13 (Auger, 2000, p. 21). Further, these deaths are typically devoid of feelings, suffering and

grief (Auger, 2000). This has interesting implications for the expected emotional response to death for both the mainstream lay population as well as the death professionals under present study, funeral directors and doctors.

Doctors have been shown to have a clinical and impersonal attitude towards death that is both justified and cultivated in their professional training (Hochschild, 1983). Students are rewarded for analyzing and reporting information about death and dying in a succinct, unemotional manner (Smith & Kleinman, 1989). Dissecting cadavers is particularly important in shaping this attitude (Smith & Kleinman, 1989; Lauder milk, 2012). This was well-illustrated by Smith & Kleinman (1989) who noted that students managed uncomfortable initial experiences with cadavers by transforming the body into a non-human object, for instance “[The pelvic exam] is pretty much like checking a toaster. It isn’t a problem. I’m good at that kind of thing” (p.61).

Death may end a physical life, but it does not sever the social relationships that characterize human experience (Auger, 2000). Funerals are symbolic rituals that artfully display the transformation from life to death and honour these social ties (Auger, 2000). Funeral directors are the gatekeepers of this ritual and may be considered “ritual specialists” (Palgi & Abramovitch, 1984). One social significance of the service, in terms of how it reflects modern death attitudes, is that it makes the intolerable, death, tolerable (Auger, 2000). Anthropologists have long emphasized the socially restorative functions of funeral rites and other death-related practices (Turner, 1969). Cross-cultural analysis reveals a wide range of these behaviours and practices, all of which serve as cultural expressions of unique value systems (Palgi & Abramovitch, 1984).

Drawing from the above literature, I will be exploring the emotional labour of these death professionals and the related “feeling rules” (Hochschild, 1983) that dictate how doctors and funeral directors believe they should feel about death. I will also make use of the concepts of surface acting, deep acting, and emotional dissonance to elucidate the complexities of emotional labour’s consequences. Contextualized by the unique relationship doctors and funeral directors have towards death compared to the death denial identified in the above literature, this project deepens our understanding of professional emotional expectations and the lived experience of emotional labour as a required aspect of one’s job.

MANAGING METHODS

My original research objectives focused on three main areas of understanding: feeling rules, emotion management strategies and death attitudes. As previously mentioned, feeling rules are the norms that govern how people believe they should feel (Hochschild, 1979; Hochschild, 1983). Explicit social roles such as the professions typically encompass their own sets of rules (Hochschild, 1983). There is little research exploring the differences between sets of feeling rules. Due to divergent methods in the literature, it is difficult to make cross-study comparisons of this concept (Wharton, 2009). Thus, there has been a call for more comparative studies, which is a gap this project happily tries to address.

Due to the exploratory nature of my research question, semi-structured interviews were the most appropriate method to capture the nuances of how emotion management strategies form and are operationalized in the professions (Berg & Lune, 2012). My data consist of 11 semi-structured, qualitative interviews with five doctors and six funeral

directors. In this study, there were a greater number of female doctors than male (4F: 1M), and conversely, more male funeral director participants than female (4M: 2F). The doctors practiced in a variety of subfields, including palliative care, geriatrics, general practice, emergency, and rural medicine. Each interview lasted approximately 40 - 60 minutes and focused on the interviewee's experiences with death and emotions in the workplace. I have attached the interview guides for funeral directors and doctors respectively (Appendix A). My inclusion criteria required participants to have practiced in Canada for a minimum of five years, which produced a varied population of participants ranging from six to forty-six years of experience in their profession (Appendix B). With the participant's consent, all interviews were audio-recorded and transcribed. All participants were assigned pseudonyms upon transcription.

I recruited participants from Halifax, Nova Scotia and rural southern Ontario through purposive sampling methods. Recruitment primarily occurred via email (See Appendix C). Recruiting participants from both provinces is justified by the national standardization of training in both professions. The minor differences in provincial licensing did not affect my research, as I focused on a universal aspect of the professions (the need to manage emotions due to encounters with death) rather than a policy-bound phenomenon.

I analyzed my data using the qualitative data analysis software "Dedoose". I coded all interview transcripts for themes deemed relevant by the literature (feeling rules, emotion management strategies, and death attitudes), as well any new themes that arose from the interviews themselves. Due to the nature of qualitative research, I was open to

findings that were not in line with the concepts I initially thought would be relevant to this topic. A comprehensive list of codes used in this study can be found in Appendix D.

I designed my project to meet the ethics standards established by the Dalhousie Research Ethics Board and the TCPS2. Of primary importance was ensuring that all my participants were able to provide informed consent. At the start of each interview, participants signed a consent form, which outlined all pertinent information (Appendix E). It was unlikely that risks or discomfort would occur when conducting my research. Although my project concerns a difficult topic for many, death is well within the realm of daily life for both funeral directors and doctors. Thus my research was not risky or likely to cause discomfort for participants; it corresponds to the TCPS2 definition of minimal risk. Regardless, I did my best to mitigate risk by creating an open, safe space where participants felt sufficiently comfortable to share their thoughts, free of judgment.

ANALYSIS & FINDINGS

Contextualizing Professional Death Attitudes

As previously discussed, societal death attitudes are characterized by death denial (Auger, 2000; Aries, 1974). If participants of either profession were afraid of death, this did not come up in the interviews, which is an interesting contrast to the existing societal fear. Participants addressed this fear in others, saying it was likely due to the fact that most people do not know what to expect with death and have a general fear of the unknown. Thus, funeral directors and doctors' familiarity with the technical aspects of death and dying were often cited as a reason for their comfort with their own mortality and others. Their shared comfort with death was illustrated by Funeral Director Clark's

comment that he never found it difficult to deal with dead bodies as it is “just another day at the office.”

All participants were quite comfortable discussing death and often spoke of their ability to guide people through the death and dying process as a great privilege and one that must be approached with respect. Both funeral directors and doctors viewed death as extremely significant. This sentiment was clear in Funeral Director Dawson’s discussion of how much people are willing to spend on weddings, “You know it always floors me that people will spend fifty grand on a wedding, you know you could be divorced in a couple years and they won’t spend eight grand on a funeral, and *a funeral is not just a day in your life, it’s your entire life in one day* [emphasis added].” Evident in the following comment from Dr. Brown, doctors equally valued death:

Walking through death with someone and walking through the birth of a child are the two greatest privileges that you can be part of as a physician or as a human. Right? So I think, in some ways, [I’ve learned to] recognize death as not something to be feared, but as a part of who we are, part of the human experience. This reflects a consistent belief among participants that death is a life event equal in importance to birth, an event that should be respected rather than feared.

I discovered several nuances in the way that the doctors and funeral directors conceptualize death. Doctors were interested in defining death, and made reference to the official diagnostic procedures they follow when pronouncing a patient dead. Doctors also spoke of dying as a process and had varying opinions on its tendency to be prolonged, hinting at a central debate in end-of-life ethics: quality vs. quantity of life.

When funeral directors discussed death, they focused more on the symbolic significance of a funeral and its pivotal role in a family's grieving process. This was illustrated by Funeral Director Edmond during his discussion of why people need to have a funeral or similar symbol of closure, saying, "the funeral is really for the living, it's not for the dead." Funeral directors also expressed that their encounters with death have shaped a greater appreciation of life. Funeral Director Almon eloquently conveyed this notion as follows:

It's just important to face [death]. I'm lucky in my profession I'm able to face death reasonably regularly. So I find it has motivated me in certain aspects of my life to get things done and not procrastinate, and appreciate life a little more because no one's immune.

Several other funeral directors shared this sentiment. Those who did not still explicitly referred to it as an expectation of their profession, as in Funeral Director Clark's comment: "Well it should [make me feel more appreciative], but I don't wake up thinking that really, but yeah it really should. There's times when you really feel and see and think that [...] but that might only last for a little bit and then you kinda get back into your old bad habits or routines."

One shared orientation that emerged was the active role funeral directors and doctors play in death and dying. Dr. Brown illustrated this well, asserting, "I think that's your responsibility [...] a good physician will walk their patient through it, not stand back and observe it." Rather than a distanced role, it is a role that demands care, compassion and immediacy. As a result, both professions have an emotionally demanding orientation towards death in the workplace, which we will now explore in greater detail.

Dead Weight: The Heavy Emotional Labour of Funeral Directors and Doctors

There are emotional expectations of funeral directors and doctors, a fact well illustrated by Funeral Director Edmond's assertion that "there's a certain care and compassion that goes with the job." As a result, a great deal of emotional labour is required in order to be a "good" funeral director or doctor. When speaking to the emotional nature of the job, Dr. Collins expresses the following:

It's probably the hardest part of the job [...] I remember stressing about the medicine so much and that was dumb. And learning some good self-care strategies really early on, how to prioritize self-care strategies, [that's] probably the smartest thing you can do for yourself to manage this stuff.

This sentiment regarding the difficulty of emotional labour was echoed in many of my interviews. This underscores how pertinent it is to better understand this labour and the processes by which these professionals manage it.

The most common management strategies for both professions were consistent with those identified in the literature, including but not limited to engaging with their friends, exercising, using humour, creating clear boundaries between work and home, physically avoiding emotionally laborious situations, partaking in hobbies and spending time with family (Hochschild, 1983; Smith & Kleinman, 1989; Mann, 2004; Lauder milk, 2012). For funeral directors, taking pride in one's profession was the most common emotion management strategy, illustrated by Funeral Director Almon's comment, "In my mind if I do these things well, that helps me deal with that death. Coming back to why I like this job and being fulfilled in it, if I can do a decent job, I feel good about it. In the end I feel like I've done all I can." The primary form of emotion management for doctors

was maintaining a scientific orientation towards death. This is exemplified in the following excerpt from my interview with Dr. Collins:

No matter how empathetic you want to be, there are periods where you have to turn into a non...you have to turn into kind of a robot. [...] In the sense that you can't be, you know, taking off the end of someone's finger, which is something you have to do sometimes, and also thinking about all the things they're not going to be able to do if they don't have this finger. You just have to do it. Technical, sometimes the technical trumps the empathetic. It has to, otherwise...empathy is useless without technical skill.

Thus, by focusing on the technical skills and remaining scientifically, albeit robotically, oriented, doctors are able to deal with the associated, potentially distracting, emotions.

The emotional pressure experienced by these professionals is exacerbated by how strongly these individuals identify with their respective careers. For instance, Funeral Director Edmond described funeral direction in the following way, "it's more of a lifestyle than a job because in our situation here it's 24/7 and you're always on call...you just learn to deal with that." Even those who expressed a desire to distance themselves from their professional identity said that they still identify strongly with their career, since it is how others primarily identify them. Funeral directors were often seen as "the death person of the community" (Funeral Director Fletcher) and doctors described being known as "the medical person in the family" (Dr. Atkins). Being viewed through these respective lenses shows that the identity of their job extends far beyond working hours; they are doctors or funeral directors 24/7, if not to themselves, then to others. As a result, there is a greater pressure to adhere to the feeling rules of emotional labour, since this

labour is so closely tied to the professional's sense of self. There were two key feeling rules that arose for both professions, to which I now turn.

Grave Expectations: Feeling Rules for Funeral Directors and Doctors

When designing this project, my main aim was to illuminate the tacit feeling rules that govern how members of each profession believe they should feel in regards to death. I was particularly interested in how these rules are managed and how they differ. Thus, arguably my most interesting finding was that identical feeling rules govern the emotional labour of both professions in respect to death. There are two main rules at play: prioritizing the emotions of others and stifling strong emotional responses in oneself.

Prioritizing Emotions of Others

Putting others' emotions first was the most common of these two feeling rules, a notion that arose frequently in all interviews. This is in part due to the way that participants in both professions framed themselves as "service providers", as illustrated by Dr. Brown, who said, "you're there to serve your patient, it's not about what you're feeling. It's about what they're feeling. Their needs come ahead of your needs." Although it is intuitive that the needs of the patient come before the needs of the doctor in a physical sense, this remark was especially interesting as it shows that this extends into the emotional state of the doctor as well. Thus, the patient is a priority in a deeper sense than one might initially assume.

The strength of this rule was evident in Funeral Director Dawson's description of what she used to tell herself at the start of her career about the emotional nature of her job: "Probably just the amount of guilt you'll feel if you're not there for a family [...] I would feel so guilty putting myself first." The use of "would" is interesting, implying that

this is a hypothetical situation and that she would never actually put herself first in practice.

Stifling Strong Emotions

The second feeling rule that emerged was that these professionals should not show strong emotions. This generally referred to negative emotions such as stress, frustration or sadness, but it also applied to positive emotions such as relief at not having to deal with an obnoxious family anymore once a patient had died. This rule was rationalized in three key ways: emotions as unprofessional, emotions as a burden, and emotions as irrational.

Emotions are regularly framed as unprofessional in the daily work lives of funeral directors and doctors. Dr. Decker described this by saying, “I’ve occasionally teared up and I’m okay with that. I think it would be inappropriate of me to break down sobbing at the bedside but that’s not going to happen because, again, that’s that professional thing, that’s not my job.” This not only exemplifies the professional link with stifling emotions, it also eloquently highlights that this rule applies primarily to strong emotional displays. An “occasional tearing up” is fine, but a stronger display, such as sobbing, violates professional emotional responsibilities.

This tie between being a professional and muting strong emotional displays was evident among funeral directors as well. For instance, Funeral Director Clark relayed the following rationale:

I’m able to kind of detach myself from the emotional side of things, and I don’t know why or how I can do that but when it’s a really tough situation and everybody around you is grieving, this is my job [...] It’s not adrenaline, but

kinda like a switch that goes on in you and you have to get it done. You have to...
they're paying you to provide a professional service and you have to do it.

[emphasis added]

Further, when I asked whether the stifling of emotions Dr. Brown described occurred often, he replied “yes, but that’s when you have to be a professional. And it’s not about you, it’s about helping them through their problems.” This not only shows that the stifling of emotions is related to professional expectations, it also encapsulates the first rule, the prioritization of others’ feelings above one’s own. Thus, this is a helpful reminder that the two rules are not mutually exclusive.

The stifling of emotions was also rationalized by framing emotion as a burden. Participants often expressed that the presence of their emotions would directly undermine the quality of care they were providing, due to the burden this would place on their patient or grieving family respectively. For instance, Funeral Director Edmond said, “you have to maintain your composure [...] in order to be a help to the family. You can’t have everybody breaking down [...] if you’re up there struggling it’s no good for anybody.” Doctors expressed similar beliefs, such as Dr. Decker when she said, “you don’t want to add to the patient’s distress.”

Emotions were also seen as irrational, negatively impacting one’s ability to provide competent care due to their perceived interference with one’s mental clarity. In scientific disciplines, such as medicine or mortuary science, emotions have long been seen as potentially disruptive, with a canonic belief that scientific fact should be kept separate from emotional influence (Peterson, 2004). This notion was evident in the reasoning behind stifling emotional displays for my participants. For example, Funeral

Director Dawson describes this clarity of thought as a key component of being a reliable care provider in the following comment: “you want to be strong for your families...you have to be their shoulder to lean on or the one that’s thinking clearly.” This reflects broader North American depictions of emotion, which are challenged in cross-cultural studies showing that in many other areas of the world emotions are framed as an outcome of social interaction and are not clearly distinct from thinking (Peterson, 2004). In other words, emotions are seen as a valued part of rationality rather than a hindrance. Returning to the North American aversion to emotions due to their irrational nature, Dr. Collins provided one potential reason that this attitude is reproduced in medicine, saying “we consistently devalue these things [...] we *talk* a lot about it but specialties that are heavy in empathy like psychiatry or family medicine, that kind of thing, those are *hugely* undervalued from a sort of medical culture perspective.” Thus, it is hard to make space for emotions in medicine if the value in this is not recognized.

Challenging the Rules: “It’s Okay to Care”

It is possible to challenge the described feeling rules. Several participants explicitly wished to distance themselves from the stereotype of the unemotional professional. However, this distancing often provided a perfect illustration of the rules from which they deviate, as seen in the following excerpt from my interview with Dr. Collins:

Earlier in my practice, when I had less experience with death [...] I didn’t feel I could cry with patients or I shouldn’t, it was *unprofessional of me to cry* with patients. The *burden of my crying* is not helping them with their problem. I gotta

deal with my own stuff. And that is mostly not...if I feel like I should cry, it's probably okay to cry [emphasis added].

Dr. Collins challenged the idea of being an unemotional professional throughout her interview, often providing similar comments deeming it “okay” to express a given emotion. The use of “okay” in the above excerpt implies that others may not think this is okay, in this case referring to the display of negative emotion. It is of note that this excerpt explicitly refers to the previously discussed feeling rule, stifling one’s strong emotional responses, and highlights two of its three key rationales, the perceived unprofessional and burdensome nature of emotions.

Another key point of conflict between the feeling rules and the lived experience of the professionals was the risk of dehumanizing both those with whom they work and themselves in order to cope with the heavy emotional demands. For instance, Dr. Brown said, “even when it’s a dead body, it’s still a person. Treat them like a person. It’s okay to be sad.” This quote illustrates the tension between humanity and professionalism; doctors are still human and emotions are part of the human experience. The risk of dehumanization is related to the early days of their medical socialization and first experiences with cadavers. Working with cadavers is a transformative experience for many medical professionals, and how it is handled can heavily influence their emotional outlook further on in their careers (Laudermilk, 2012; Smith & Kleinman, 1989). For instance, Dr. Collins describes working with cadavers in the following way:

It was the first piece of socialization to be a doctor in that you have, it’s weird right, you had to turn people into their little parts, identify their little tiny nerve or whatever, so you turn people, you dehumanize them completely [...] I remember

the afternoon of the first day some dude showed up with a saw, like an electric chain saw type of thing just to crack open the chest cavity, like how dehumanizing is that? For you *and* the cadaver. It was an incredibly dehumanizing experience.

Further illustrating this tension, when reflecting upon what she would tell herself at the start of her career about the emotional nature of her job, Dr. Atkins insisted, “Let yourself be human.”

Conversely, funeral directors were trained in a setting that preserved the humanity of the dead body. This was evident when Funeral Director Clark relayed to me how he learned to embalm in school, saying “There’s lots of funeral homes that provide [my school] with those bodies, so we never really dealt with cadavers at all. It was real people.” This is interesting as it implies that cadavers are not real people. These bodies will have an actual funeral service after the students have completed their work. This speaks to a fundamental difference in the training foci of each profession: doctors dissect, slicing the body into pieces to learn how it works; funeral directors create, aiming to make the dead look life-like.

It is of note that all explicit challenges posed to the feeling rules came from my interviews with doctors and mentions of similar challenges to the rules were absent in discussions with funeral directors. This could be due to the relative level of autonomy felt by each profession. Doctors were quite autonomous and when experiencing tough situations often recounted some solution they had been able to enact. For example, Dr. Collins talked about the frustration of working with families who are trying to convince a dying family member to follow the wishes of the family rather than their own:

I sometimes feel like they're being coerced by their family a little bit. Like they don't want to disappoint their kids or their family or their spouse or whoever. So for those patients, I think the key is to get the families out of the room and talk to [the patient] alone. And I frequently do that. I just say 'I'm kicking you all out', as lovely as that...and actually the families respond to that.

Conversely, funeral directors were more likely to cite difficulties of this type as part of the job, and placed greater weight than doctors on the first feeling rule, putting others' emotions first.

Consequences of Emotional Labour

As the previous discussion of the literature alluded, heavy emotional labour in the workplace can result in emotional alienation (Hochschild, 1983). Further, workers who perform an abundance of emotion work may lose touch with what they consider to be their true emotions (Hochschild, 1983; Sloan, 2007). This was evident in Dr. Decker's description of not being able to feel personal emotions following a recent family death: "I wanted to access the fact that this was my aunt who obviously I've known all my life and I still don't think I've really accessed that because I went in as the doctor." Since she approached the situation in her "doctor role", her subsequent focus on palliative care and maintaining a scientific orientation directly impeded her ability to engage her personal feelings in the matter. At the time of the interview this had occurred a few weeks prior and she felt she still had not been able to truly experience her personal feelings, exemplifying a very real risk of emotional labour as a required part of one's job.

Another risk of heavy emotional labour is emotional burnout, which can occur when one exceeds one's emotional capacity. Reaching one's emotional capacity was

discussed more frequently among the doctors than the funeral directors. In fact, when I asked each profession how they thought the other perceived death, Funeral Director Almon expressed that being a doctor is beyond his emotional capacity, saying, “I don’t think I could do that. I know I couldn’t do that.” However, emotional dissonance, which is the display of feelings that do not match one’s true feelings, was more common among the funeral directors than doctors (Dijk & Brown, 2006). For instance, when speaking to the difficulties of experiencing emotional dissonance, Funeral Director Baker relayed the following example:

I was working with somebody and you know, [they were] explaining to me that homosexuality is a disease and it’s brought by Satan himself. And in so many workplaces you can say, you know, ‘I don’t agree with that, go away’. But in my workplace you say ‘Okay, so now let’s work with that.’ Those types of things.

In this excerpt, a key theme is illustrated: funeral directors felt the need to constantly accommodate, despite the personal challenges this emotion management entails.

Thus, doctors seemed to call upon their emotions more often, risking a maxing out of their capacity, whereas funeral directors were more likely to burn out as a result of displaying conflicting emotions more regularly. This is likely linked to their respective uses of deep acting and surface acting. Doctors have retrained their emotional response, in other words, they employ “deep acting” to call upon true emotions. For instance, when speaking to her most recent experience with a dead body in the workplace, Dr. Elm described her emotional response in the following way: “I think it never really changes, it’s almost as if you’re emotionally primed to have the same reaction every time [...] you have to put on your professional hat, you know, to not tear up or become emotional.”

Conversely, funeral directors present the appropriate surface response without necessarily changing what they truly feel on a personal level and thus are not burning out their personal emotional capacities.

Previous studies have shown that surface acting has detrimental effects on the worker, whereas deep acting is solely positive and often generates a sense of personal accomplishment (Brotheridge & Grandey, 2002). However, this is in direct contrast with my findings. I argue that the use of deep acting or surface acting to manage emotions in the workplace is more complex than a simple dichotomy of one being beneficial and the other detrimental. Rather, the heavy reliance on one method over the other can lead the worker towards emotional burnout in two different ways: either by maxing out one's emotional capacity (deep acting) or through the frequent occurrence of emotional dissonance (surface acting). Thus, although in the context of death, the emotional labour of these professionals is governed by the same feeling rules, their differing orientation towards death and relative level of autonomy pose different risks towards experiencing emotional burnout.

Implications and Future Directions

One possible practical application of this study is informing end-of-life training programs for both professions, perhaps encouraging the integration of more emotion management classes and workshops. However, most interviewees were highly critical of the possibility of teaching emotion management skills in the classroom. Rather, learning how to manage one's emotions was described to be an individual process, learned primarily through personal experience. For instance, Dr. Brown described her emotion management development in the following way, "It's just an evolution that has to happen

[...] [It] can only be experienced.” Further, its individual nature was described well by Dr. Collins when she said, “There was definitely this like ‘you can’t talk about this stuff’, it was only years later [...] that I could really you know, really kind of process what had happened and how it had been important.” This supports previous studies that have demonstrated the privatization and downplay of emotions in medical school (Smith & Kleinman, 1989). By privatizing their feelings in order to appear professional, students believe their peers are simply handling situations better than they are themselves, and refrain from discussing their feelings and related coping mechanisms.

This was expressed by funeral directors as well, as illustrated by Funeral Director Fletcher, who said, “At the beginning of the career, [there are] some things that I guess you just deal with on your own and it’s something you can’t probably talk about with other people that easily, and things that you see and hear are things that you don’t forget.” This phenomenon of privatization has interesting implications then for how management strategies are formed and operationalized; it supports the potential merit of opening up this discussion both among professionals and between professions (Hegedus et al., 2008).

Emotional learning did not always occur individually. Many participants expressed the intimate role that mentorship played in development of their emotion management strategies. For instance, Dr. Brown expressed the importance of mentors when learning to care in all ways: “Mentors are a huge role in learning how to care for people. Well, mentors are a huge role in learning how to love, outside of medicine right? Hopefully you can learn from others’ experiences and not have to screw up yourself.” An example of what most participants considered to be helpful mentoring was the act of “debriefing” after stressful events, such as for doctors the first time a patient died while

they were working. Funeral Director Dawson, who often mentioned her gratitude for the mentorship she had received, illustrated the role of mentoring for funeral directors in the following excerpt from our interview:

Before [my old boss] would do anything, he would say ‘this is what I’m going to do.’ And it’s hard to for us too, once you’ve been in this business long enough those things become normal to you so it’s hard to remember to tell people that are new, ‘this is what’s going to happen’ so they’re not like ‘Oh my goodness!’ right? And you don’t shock them or scare them. [...] He was very relaxed and that kind of stuff probably played into me being pretty good about everything.

Thus, having had a mentor who was careful to always check in and debrief, she felt that she was quite comfortable with her emotion management skills.

Further, all participants expressed that learning how to deal with the emotional labour of the job is important, even if they themselves did not identify as someone particularly skilled at this emotion management. One example of this was Funeral Director Clark’s remark, “I’m not one to share much of my feelings but it’s healthy to do it.” This speaks to the significance of taking care of oneself and one’s emotions in jobs that call for high quantities of emotional labour, such as the professions highlighted in this study. As Dr. Decker said, “If you don’t look after yourself, you can’t look after anybody else.” Therefore, in the future it would be helpful to create more space in these professions for emotional debriefing, including discussions of how frequent encounters with death have made these professionals feel.

CONCLUSION

“You do not have to be a robot. It’s totally okay to cry. It’s okay to care.” – Dr. Elm

Emotional labour serves an important societal function; it is desirable to have funeral directors and doctors who are calm and compassionate in the face of death. Thus, emotional labour is a necessary performance and the processes that make it possible are worthy of study. By exploring the emotion management and death attitudes of these death professionals, I have identified two key rules that dictate how funeral directors and doctors believe they should feel in regards to death: prioritizing the emotions of others and stifling one’s own strong emotions. However, these rules can be challenged and do not dictate how all professionals manage their emotions. With these findings, this study contributes to the improved understanding of the processes of emotional labour. Beyond funeral directors and doctors, findings from this study may also be of interest to other death professionals, such as hospice care workers.

In the past, studies of emotional labour in the workforce have focused on a single occupation, rendering it difficult to compare sets of feeling rules between professions (Wharton, 2009). Comparative studies such as this one are required in order to further our understanding of both the formation and operationalization of emotion management strategies. I have shown that although similar sets of feeling rules emerge in both medicine and funeral direction, there is great nuance in the meaning they have for each profession. Differences arose in terms of how these rules are managed and what the related emotional consequences may be, due to their respective reliance on surface acting and deep acting emotion management strategies. In the future, it would also be helpful to complement existing research with participant observation studies in order to better

illuminate the meaning that emotional labour has for individuals in practice (Bianchi et al., 2014).

By presenting the comfortable relationship doctors and funeral directors have with death, this study also hopes to challenge, or at the very least complicate, the taboo nature of death in contemporary North American society. This is an ambitious and timely endeavour, as in Canada we are seeing recent changes to physician-assisted suicide legislation as well as a general push to demystify what one intensive care unit physician, Dr. Jessica Zitter, identifies to be “society’s last taboo” (Tremonti, 2017). In a recent CBC article, Dr. Zitter asks readers to consider, “If sex ed exists in high school curriculums, why not death ed?” (Tremonti, 2017). To quote my own research participant Funeral Director Almon, when it comes to death “no one’s immune.” Therefore, why not better prepare the public for the inevitable and open up an overdue discussion? There is no doubt that death is emotional, but studying the emotional labour of these death professionals serves as a fine reminder that these emotions are manageable.

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Appendices

APPENDIX A: Interview Guides

Interview Guide, Doctors

Interviews with doctors will be in-depth, semi-structured and last about one hour.

Questions will be as follows.

1. How long have you been practicing as a physician?
2. How strongly do you identify with your career?
 - a. Do you ever really hang up your doctor hat or is it always on in some respect?
3. How do you emotionally unwind at the end of a workday?
 - a. Do you have any specific strategies you rely on?
4. Do you feel differently about death than you did prior to medical school?
 - a. What about 10 years ago? 5 years ago? Last year?
5. Could you describe your first experience with a dead body for me?
 - a. Specifically, can you speak to your first experience with cadaver dissection? How did this impact you, if at all?
 - b. How about the first time you dealt with a patient who died?
 - c. What was your most recent experience with a dead body like?
6. Do you feel differently about death in your personal life than in your professional role?
 - a. If so, how do you keep these perspectives separate?
7. Do you think your perception of death differs from that of your colleagues?
 - a. If so, how?
 - b. Do you think others would benefit from seeing death the way you do? Why or why not?
8. How do you think funeral directors perceive death?
9. How often do you discuss death:
 - a. With family and friends?
 - b. With fellow colleagues?
10. Can you think of any examples of times at work in which you felt an emotion that was not appropriate for the given situation?
 - a. What did you do to 'manage' the emotion?
 - b. How often do moments like these occur?
11. Did you receive any formal training in emotion management?
 - a. If so, how was it? Was it useful?
 - b. If not, what would you want a trainee to know?
12. In light of our conversation, is there anything you wish you could tell yourself at the start of your career about the emotional nature of your job?
 - a. In the same vein, is there anything you wish you had known about what it is like to encounter and experience death as part of a job?
13. Geoffrey Gorer, a sociologist, argued that death is the 'ultimate unmentionable' in contemporary culture. What are your thoughts on this?

Interview Guide, Funeral Directors

Interviews with funeral directors will be in-depth, semi-structured and last about one hour. Questions will be as follows.

1. How long have you been practicing as a funeral director?
 - a. Could you briefly describe your career path?
2. How strongly do you identify with your career?
3. How do you emotionally unwind at the end of a workday?
 - a. Do you have any specific strategies you rely on?
4. Could you describe your first experience with a dead body for me?
 - a. What was your most recent experience with a dead body like?
5. Do you feel differently about death in your personal life than in your professional role?
 - a. If so, how do you keep these perspectives separate?
6. Do you think your perception of death differs from that of your colleagues?
 - a. If so, how?
 - b. Do you think others would benefit from seeing death the way you do? Why or why not?
7. How do you think doctors perceive death?
8. How often do you discuss death:
 - a. With family and friends?
 - b. With fellow colleagues?
9. There is a very clear front-stage/backstage element in to funeral homes. Do you ever feel as if you are putting on a performance at work?
 - a. If so, how?
10. Can you think of any examples of times at work in which you felt an emotion that was not appropriate for the given situation?
 - a. What did you do to 'manage' the emotion?
 - b. How often do moments like these occur?
11. Did you receive any formal training in emotion management?
 - a. If so, how was it? Was it useful?
 - b. If not, what would you want a trainee to know?
12. In light of our conversation, is there anything you wish you could tell yourself at the start of your career about the emotional nature of your job?
 - a. In the same vein, is there anything you wish you had known about what it is like to encounter and experience death as part of a job?
13. Geoffrey Gorer, a sociologist, argued that death is the 'ultimate unmentionable' in contemporary culture. What are your thoughts on this?

APPENDIX B: Table of Participants

Pseudonym	Years of Experience in Profession
Dr. Atkins	25
Dr. Brown	19
Dr. Collins	6
Dr. Decker	39
Dr. Elm	12
Fd. Almon	20
Fd. Baker	20
Fd. Clark	17
Fd. Dawson	6
Fd. Edmond	30
Fd. Fletcher	46

APPENDIX C: Recruitment Email

Good afternoon -----,

I am a social anthropology student from Dalhousie University and I am conducting a research study for my Honours thesis exploring how funeral directors and doctors manage their emotions during their everyday work. I would truly appreciate the opportunity to discuss this with you.

I grew up in ----- County and am currently home for the holidays hoping to include as many local voices as possible. Participation consists of a single interview, lasting up to one hour. All information you provide will be anonymized, and your identity will be kept secure and confidential.

For more information, please contact me by email (ml639743@dal.ca) or phone (902-402-7981).

Thank you for your time.

All the best,

Molly Ryan

APPENDIX D: List of Analytic Codes

Title	Description
DthAtt	Death attitudes
PER	personal death attitude
PRO	professional death attitude
CH	change in death attitude
SOC	societal death attitude
LIFE	death as life
MED	medicalization of death
KID	how they approach death w their kids
SHELL	body as empty/"lights are out"
SIG	Social significance of death
APR	appreciation for life as a result of encountering death frequently
ID	talking about how they identify with career (strong/weak)
URBRUR	small town different than city experience
MEM	explicit references to their memory or capability to remember certain things
FRU	frustrated with weak memory

Good/Bad	
G/B Doc	what makes a g/b doc
G/B FD	what makes a g/b FD
G/B Fun	good/bad funeral 1= good 2= bad
G/B Death	good bad death
C	good/bad bc of cause
Age	good/bad bc of age
EMOTMAN	emotion management
EMOTLAB	management as something that must be worked at; OR expressing emotion work
EMOTDISS	emotional dissonance: feeling displayed does not match feeling felt
RULE	feeling rule / "emotional responsibilities" ways they "should" feel
CAP	idea that there is a max. emotional capacity (linked to ideas of burnout/only so much one can handle)
PROF	professionalism and emotions
OTH	Putting others emotions before yourself
TRA	formal training in emotion management
FORM	formation of emot mang. strategies
M	mentorship
EX	lived experience
IND	individualized development
STRAT	explicit emotion management strategies
HUM	humour
PA	physical avoidance
PRI	pride in a job well done
SCI	focus on science
TALK	talking to dead body
CONF	confiding in spouse/close confidant
ROB	robotic / becoming emotionally numb
FAM	spending time with family
AUT	autonomy as emot mang
WKHM	separating work and home spatially and/or temporarily
HOB	hobbies / exercise
PERF	performative / acting / chameleon like

CONSENT FORM

Dying Professions: Exploring Emotion Management & Contemporary Death Attitudes among Doctors and Funeral Directors

You are invited to take part in research being conducted by me, Molly Ryan, an undergraduate student in Social Anthropology, as part of my honours degree at Dalhousie University. The purpose of this research is to interview funeral directors and doctors to understand how frequent death encounters shape their emotion management strategies. I will write up the results of this research in a paper for my class, called the honours thesis.

As a participant in the research you will be asked to answer a number of interview questions about your professional experience with death and the emotions it entails. The interview should take about an hour and will be conducted in a quiet location of your choice. With your permission, the interview will be audio-recorded. If I quote any part of it in my honours thesis, I will use a pseudonym, not your real name, and I will remove any other details that could identify you from the quote.

Information that you provide to me will be kept private and will be anonymized, which means any identifying details such as your name will be removed from it. Only the honours class supervisor and I will have access to the unprocessed information you offer. I will describe and share general findings in a presentation to the Sociology and Social Anthropology Department and in my honours thesis. Nothing that could identify you will be included in the presentation or the thesis. I will keep anonymized information so that I can learn more from it as I continue with my studies.

Your participation in this research is entirely voluntary. You do not have to answer questions that you do not want to answer, and you are welcome to stop the interview at any time if you no longer want to participate. If you decide to stop participating after the interview is over, you can do so until March 1, 2017. I will not be able to remove the information you provided after that date, because I will have completed my analysis, but the information will not be used in any other research.

The risks associated with this study are no greater than those you encounter in your everyday life.

There will be no direct benefit to you in participating in this research and you will not receive compensation. The research, however, will contribute to new knowledge on emotion management in the professions, as well as contemporary perceptions of death on a larger scale. If you would like to see how your information is used, please feel free to contact me and I will send you a copy of my honours thesis after April 30, 2017. I can also send you a copy of your interview transcript if you wish.

If you have questions or concerns about the research, please feel free to contact me or the honours class supervisor. My contact information is ml639743@dal.ca. You can contact the honours class supervisor, Dr. Martha Radice, at the Department of Sociology and Social Anthropology, Dalhousie University on (902) 494-6747, or email martha.radice@dal.ca.

If you have any ethical concerns about your participation in this research, you may contact Catherine Connors, Director, Research Ethics, Dalhousie University at (902) 494-1462, or email ethics@dal.ca.

Participant's consent:

I have read the above information and I agree to participate in this study.

I agree that the researcher can audio-record my interview.

Name: _____

Signature: _____

Date: _____

Researcher's signature: _____

Date: _____

APPENDIX F: REB Final Report



ANNUAL/FINAL REPORT

Annual report to the Research Ethics Board for the continuing ethical review of research involving humans and final report to conclude REB Approval

A. ADMINISTRATIVE INFORMATION

A1. Lead researcher contact	
Name:	Molly Ryan
Email address:	ml639743@dal.ca
For student research:	
Supervisor at Dal:	Dr. Martha Radice
Supervisor email:	martha.radice@dal.ca

A2. Lead Researcher Status
Please indicate your current status with Dalhousie University: <input type="checkbox"/> Employee/Academic Appointment <input checked="" type="checkbox"/> Current student <input type="checkbox"/> Other (please explain):

A3. Project Information	
REB file #:	2016-4043
Project title:	Dying Professions: Exploring Emotion Management Among Doctors and Funeral Directors
Sample size (or number of cases) approved by REB:	approximately 10

B. STUDY STATUS

B1. Study progress (check all that apply)			
<input type="checkbox"/> Participant recruitment not yet begun Reason (please explain):			
		During past year	Total since study start
<input type="checkbox"/> Secondary data use (no recruitment) Number of records used:			
<input type="checkbox"/> Participant recruitment on-going Number of participants recruited (by group):			
<input checked="" type="checkbox"/> Participant recruitment complete Total number of participants/records:		11	11
<input type="checkbox"/> Data collection on-going			
<input checked="" type="checkbox"/> Study complete. Data collection complete. No further involvement of participants. Approved data analysis and writing may be ongoing. This report is the final report to close the REB file for this project.			
<input type="checkbox"/> Other (describe):			

B2. Study Changes
Have you made any changes to the approved research project (that have not been documented with an amendment request)? This includes changes to the research methods, recruitment material, consent documents and/or study instruments or research team. <div style="text-align: right;"><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>
If yes, please explain:

C. PROJECT HISTORY

Since your initial REB submission or last annual report:	
C1. Have you experienced any challenges or delays recruiting or retaining participants or accessing records or biological materials? If yes, please describe:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
C2. Have you experienced any problems in carrying out this project? If yes, please describe:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

<p>C3. Have participants experienced any harm as a result of their participation in the study? If yes, please describe:</p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
<p>C4. Has any study participant expressed complaints, or experienced any difficulties in relation to their participation in the study? If yes, please describe:</p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
<p>C5. Since the original approval, have there been any new reports in the literature that would suggest a change in the nature or likelihood of risks or benefits resulting from participation in this study? If yes, please describe:</p>	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>

D. ATTESTATION (this box *must be checked* for the report to be accepted by the REB)

- I agree that the information provided in this report accurately portrays the status of this project and describes to the Research Ethics Board any new developments related to the study since initial approval or the latest report.

E. SUBMISSION INSTRUCTIONS

1. Submit this completed form to Research Ethics, Dalhousie University, by email at ethics@dal.ca at least 21 days prior to the expiry date of your current Research Ethics Board approval.
2. Enter subject line: REB# (8-digit number), Last name, Annual (or Final) Report.
3. Student researchers must copy their supervisor(s) in the cc. line of the Annual / Final Report email.

F. RESPONSE FROM THE REB

Your report will be reviewed and any follow-up inquiries will be directed to you. You must respond to inquiries as part of the continuing review process. Annual reports will be reviewed and may be approved for up to an additional 12 months; you will receive an annual renewal letter of approval from the Board that will include your new expiry date. Final reports will be reviewed and acknowledged in writing.

CONTACT RESEARCH ETHICS

- Phone: 902.494.3423
- Email: ethics@dal.ca
- In person: Hicks Academic Administration Building, 6299 South Street, Suite 231
- By mail: PO Box 15000, Halifax, NS B3H 4R2