LEADERSHIP PERSPECTIVES ON OFFERING SOCIAL SUPPORT:
PROBLEMATIC INTEGRATION AND THE HEALTH CRISIS

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CHAPTER I
INTRODUCTION

Most communication about health does not take place within the confines of a doctor’s office or hospital (du Pre, 2010). A diagnosis of disease or illness can raise many questions and concerns for patients: How serious is it? Will I recover? How long do I have to live? What treatment options do I have? Health communication can be defined as "the way we seek, process, and share health information" (Kreps & Thornton, 1992, p. 2). Discourse about health can occur in several contexts. Examples of this discourse include the patient-provider relationship, among friends and coworkers, within the pages of magazines, on news programs, and in the entertainment programming we watch on television and in movies.

Interpersonal communication in the form of social support can play a major role in an individual’s life by enhancing health and wellbeing (Segrin & Passalacqua, 2010). Social support can be broadly defined as the “existence or availability of people on whom we can rely, people who let us know that they care about, value and love us” (Sarason, Levine, Basham & Sarason, 1983, p.127). Hence, social support can mean a variety of things to many different people. To one, it may mean having a shoulder to cry on after the end of a relationship. For another, it may mean a monetary loan until payday. But for those with health concerns, social support can mean something entirely different. A kind word when someone is feeling ill can raise spirits. A late-night phone call to a
friend for advice about a sick child can solve a problem. Transportation to a medical appointment can mean the difference between life and death. Social support in a health context refers to both verbal and nonverbal messages that are useful for managing health-related uncertainty about the health situation, the self, or the other and which work to enhance the perception of personal control in one’s life experience (Albrecht & Goldsmith, 2003). Several sources can provide this type of support, and research shows that individuals employed outside the home have access to a larger support network (Ruesch, Graf, Meyer, Rossler, & Hell, 2004).

Illness and disease can present many unanswered questions for the individual diagnosed as well as family, friends, coworkers, teammates, and the like. Social support communication has many functions. These include offering tangible assistance, managing uncertainty, providing information, hope, or motivation, increasing perception of control and ability to achieve positive health behaviors, enhancing training and skills, making referrals and facilitating coping (Albrecht & Goldsmith, 2003). Social support is also linked to reductions in stress and high blood pressure, conditions which can result from loneliness and compound the health problem (Se grin & Passalacqua, 2010).

When an individual is employed outside the home, that person may have a larger group from which to seek support. However, the workplace may present additional stressors to the employee facing a health crisis. Illness-related absence, inability to perform a job, and fear of subsequent termination from the workplace as well as coworker perceptions are a few factors that may cause further concern. Leadership style can have a significant impact on the stress an employee perceives. Hackman and Johnson (2009) discuss several leadership styles, such as democratic, authoritarian,
task-oriented, relationship-oriented, transformational, and transactional. No one style is ideal, nor are the styles mutually exclusive (Sims, 2009).

Hackman and Johnson (2009) assert that leaders play an integral role in creating workplace culture. Furthermore, according to Rooney et al. (2010), leaders can reinforce employee feelings of value by engaging in open and effective communication.

Many studies examine social support as it pertains to work-related stress. There is also sufficient research on the importance of open communication between leaders and followers. However, inadequate research exists on social support offered specifically by leaders as it relates to the health crisis. This thesis will address this gap by investigating the ways leaders offer social support to followers in a health crisis. Using the Theory of Problematic Integration, which posits that new information can be troubling and that communication acts to transform the troubling message in different ways, this thesis will examine the ways in which followers’ health crises are troubling for leaders and how social support communication is offered to enhance the situation.

The next portion of this thesis will begin with a description of social support and its roots. Functions and sources of social support will be addressed, as well as social competency and its role in offering support. Next, the Theory of Problematic Integration is defined, followed by a discussion of how it relates to the health crisis. Finally, the literature will conclude with a discussion on leadership, including responsibilities and dimensions of effective leadership.
CHAPTER II
LITERATURE REVIEW

This section begins with background and functions of social support, social competency and its application to health crisis, and finally, sources of social support and its use in the workplace. Then, the Theory of Problematic Integration will be introduced and applied to the health crisis. Finally, a review of existing literature on leadership will be presented, including discussion on leadership responsibilities as well as the importance of emotional intelligence, flexibility, and communication between leaders and followers. This informational groundwork provides a foundation to investigate how leaders describe the health crisis as problematic as well as how they utilize social support during the health crisis to help followers.

Social Support

Description

Albrecht and Goldsmith (2003) believe that social support is a “communication behavior as fundamental to interaction as the communication behaviors of informing, persuading, or teaching” (p.263). Cobb (1976) describes social support as information that leads an individual to believe that he/she is cared for and loved, has personal worth and value, and belongs to a network of communication and obligation. This type of communication has two levels at which it influences the wellbeing of the participants: the literal content and the relational message (Segrin & Passalacqua, 2010). The literal content refers to the
exact nature of the message. Offering good advice can bring about solutions or improvements to the situation the individual is in. The relational message of the communication is what affirms that the recipient of the message has value and is cared for. People have a need for human connection and meaning, which can be met by engaging in supportive exchanges (Albrecht & Goldsmith, 2003).

History

Although the terminology has changed over time, Albrecht and Goldsmith (2003) state that several researchers across several disciplines have long recognized the significance of supportive communication for quality of life. In 1987, Schilling (as cited in Rahim, 1997) asserted that social support was a complex phenomenon and at that time, research rendered the concept vague and undefined. However, the beneficial effects of social support can be traced back to the Middle Ages (Cline, 1999). Predecessors to modern self-help groups emerged originally to meet survival needs, and evolved to address unmet needs of the poor, underprivileged, and powerless due to shortcomings in church and government programs. A 1994 study by Wuthnow reports that 40% of adults in the United States participate regularly in an organized small group that provides support for its members. Two-thirds of respondents in the study reported that their need for deep, emotional support was met by membership in these groups. Cline (1999) cites Tyler, who in the 1990s claimed that observers believed that self-help groups would become standard practice, if not the major method of care.

At the core of the self-help group is the ability for an individual to offer assistance while at the same time, receive assistance (Flora, Raftopolous, & Pontikes, 2010). These groups offer substantive advice and emotional support, and group ideologies and values
are assumed to help members attain an increased consciousness of the self. The motivation of the self-help group is to overcome a sense of powerlessness. These groups usually consist of a homogenous population that meet to offer guidance for fulfillment of a mutual need, to confront a universal difficulty or problem that threatens the lives or wellbeing of group members, and to actualize a desired change. This change can include a physical improvement, a mental improvement, or simply a better understanding of the situation.

Historically, the geographic community, including the extended family, was responsible for providing its members with social support. However, the community was challenged by industrialization and technology expansion. Social support groups surfaced to provide a substitute for community (Wuthnow, 1994).

Wuthnow (1994) discusses the anonymity and division that replaced community and social bonding in the late 20th century. Research by Cluck and Cline (1986) and Daniolos (1994) indicates alcoholics, people with AIDS, and those mourning a death reported being misunderstood, feeling rushed to end their grieving, and rejected as their families and friends continue with their lives. Those in society who are stigmatized often face difficulties when discussing their problems with others who are not labeled in the same way. Behaviors associated with this stigmatization can lead to the invalidating of one’s worth, inappropriate joking about the person or their condition, resulting ultimately in isolation (Wright, 1998).

As personal communities of support disappeared, people began to turn to professionals. Professionals, however, tend to frame problems as deficiencies of the individual and lack any profound feeling for the bereaved, according to Cluck and Cline
(1986). Providers have also been charged with maintaining social distance, creating an impersonal and methodical climate. When professional opinion replaces social support, community-building ability is hindered.

Functions

Past research shows that people cope best when they feel well informed and actively involved (du Pre, 2010). According to Albrecht and Goldsmith (2003), social support has many functions: “providing a sense of reassurance, validation, and acceptance, the sharing of needed resources and assistance, and connecting or integrating structurally within a web of ties in a supportive network” (p. 265). Furthermore, social support can affect the physical being as well as the psychological being.

Albrecht and Goldsmith (2003) identify perceived stress and health behaviors as significant elements of the relationship between social support and wellbeing. A subjective concept, stress is a consequence of demands in both the internal and external environment that are perceived to be outside of one’s capability (Lin, Probst, & Hsu, 2010). Those who perceive their situation to be stressful more often suffer from compromised physiological resilience, thus creating susceptibility to illness (Segrin & Passalacqua, 2010). Rahim (1997) states that social support systems and personality characteristics can be used to afford some individuals virtual immunity to stress-induced illness while leaving others relatively susceptible.

Research on occupational stress by Bellman, Forster, Still, and Cooper (2003) shows that women may use social support more than men to protect against the harmful effects of stress. The same research indicates that the buffering effect of social support may vary among stressors and stress outcomes. Personality characteristics such as
hardiness, motivation, and sense of control, combined with social support, act to regulate the effects of stress. Most evidence shows a link between increased social support and stress reduction, but Bellman et al. (2003) assert that stress can increase due to the existence of unhealthy relationships.

Social support is valuable to health, because it reduces loneliness, which is otherwise harmful to health (Segrin & Passalacqua, 2010). Segrin and Passalacqua (2010) define loneliness as the result of an incongruity between desired and actualized social contact. Research by Hawkley and Cacioppo (2007) suggests five mechanisms are affected by loneliness: health behaviors, exposure to stressful life events, perceived stress and coping, stress responses, and recuperative processes. It is the contention of Segrin and Passalacqua (2010) that over time, the effect of loneliness on these mechanisms builds and leads to a decline in physiological responses, which results in a decline in health. Loneliness is associated with high blood pressure, poor sleep, elevated body mass index and increased tendencies to use tobacco and consume alcohol.

According to Cacioppo, Bernston, Sheridan, and McClintock (2000), people begin to form connections with others from the moment they are born, and this association with others is necessary for physical and psychological wellbeing throughout life. Cacioppo et al. contend that positive social support cancels the negative effects of social isolation by helping recipients to better adapt the ways they manage both acute and chronic stress, improve their health behavioral patterns, improve their beliefs and attitudes about life and sense of worth, increase hope for the future, and deepen their awareness of life purpose. Social support is also expected to improve immune functioning (Albrecht & Goldsmith, 2003; Schwarzer & Leppin, 1991). Supportive
relationships are also beneficial to health because they provide influence by transmitting social norms or invoking compliance-gaining strategies, including seeking medical attention when ill and avoiding risky behaviors (Cline, 2003).

Support can come in many forms, including action-facilitating or problem-solving, and nurturing support (du Pre, 2010). Action-facilitating support includes instrumental assistance in the form of tangible aid, such as transportation to an appointment, picking up prescriptions or running errands, as well as informational support that provides advice and information. Nurturing support pertains to contributions toward esteem and emotions. This would include expressions of concern, belonging, and letting the individual know they are valued (Schwarzer & Leppin, 1991). However, it should be noted that support could be less effective in certain situations. Albrecht and Goldsmith (2003) ascertain that tangible support may not benefit those with less severe illnesses and may, in fact, appear intrusive. Additionally, advice can be viewed the same way. Health and well being are reliant on what the individual perceives, not whether the support is accurate (Schwarzer & Leppin, 1991).

Increasing a person’s sense of control during times of health crisis is perhaps the main function of social support. An individual’s ability to adapt can determine the need for social support. People use different tactics to make sense of their world. According to du Pre (2010), individuals reject support for different reasons. Those with an internal locus of control feel that they are responsible for their circumstances and fate. These people may be discouraged by illness (seen as a personal failure) and are therefore reluctant to ask for help. Conversely, those with an external locus of control believe that experiences are controlled mostly by outside forces, over which they have no control.
These individuals may have difficulty adhering to advice because they feel they have no control over their situation and no action they could take would make a difference.

Social Competency

Chamberlin-Quinlisk’s (2007) essay refers to studies in social competency, which is defined as “a set of experiences and behaviors that increase one’s ability to adapt to novel situations” (p. 5). Adaptability is considered a communicative resource. While her research is focused on intercultural interactions, the author describes Duran’s (1992) six dimensions of communicative adaptability, which are easily applicable to the idea of social support in the health context: social experience, social composure, social confirmation, appropriate disclosure, articulation, and wit.

The first dimension, social experience, is measured by one’s familiarity with and desire to take part in novel communicative contexts. Often times, the health crisis is a new and unfamiliar experience. How much and what type of information one seeks depends on previous understanding of similar events and their wish to participate in the process. For example, if a young newlywed is faced with a situation in which her spouse is seriously injured, will a show of emotion prevent staff from sharing bad news because they feel she is psychologically unable to accept it? If she doesn’t show emotion, will staff interpret her lack of affect as indifference, leading them to believe she does not care to receive information?

Social composure, the second dimension, refers to how at ease a person is in the social setting. According to Duran (1992), composure influences anxiety levels, affecting how the situation is interpreted and responded to, potentially impeding effective communication. If an individual is overly anxious, they may not present their questions
or concerns appropriately. Moreover, they may be less likely to interpret advice correctly if they are still reeling from the shock of a serious diagnosis.

The third dimension of social competency is social confirmation. This dimension is concerned with how well an individual recognizes the self-image of others and reinforces that image by respecting the person. Many times, those with illness or disease, especially stigmatized illnesses, fear rejection due to the nature of the ailment. Support can be communicated verbally and non-verbally to show consideration of another’s feelings and to convey a sense of warmth (Chamberlin-Quinlisk, 2007).

Appropriate disclosure, the fourth dimension, is identified as knowing what, when and with whom personal information is suitable to share. This disclosure is guided by the physical setting. For example, it may be appropriate to share news of a pregnancy at a dinner with friends, but not in a business meeting. Furthermore, one may not appreciate a support person discussing a diagnosis of irritable bowel syndrome in the check out lane at the grocery store.

Relevant to the fifth dimension of articulation is the perception of the self as an effective communicator in terms of pronunciation, grammar, and appropriate words. If a health condition is complex, the individual may be confused about the terminology used to describe the condition, and this may hinder the request for social support. Conversely, if the provider of social support mispronounces words and seems otherwise unaware of the health situation, the support may not be effective.

The last dimension, wit, refers to the appropriate use of humor. Wit can be used as a way to reduce anxiety, both by the provider of social support as well as the recipient. Chamberlin-Quinlisk (2007) posits that these six dimensions can be used to effectively
adapt to new or unpredictable situations. Each of these dimensions can affect from whom support is sought, as well as whether the support is effective.

Sources

Social researchers describe a social network as a way to understand different interpersonal dynamics that take place within the immediate environment of people. A variety of relationships that people maintain with others and that can directly impact the wellbeing of people are reflected in these networks (Shu & Chuang, 2011).

A support network varies from person to person in terms of size, density (the degree to which members in the network are connected to each other), strength of the relational ties, and the extent to which the network is similar or different in terms of sociodemographic characteristics, personalities and character traits (Albrecht & Goldsmith, 2003). Cohen and Wills (as cited in Bellman et al. 2003), maintain that social support is measured in terms of the frequency and number of social contacts made. However, the effectiveness of the support is indicated not by the number of contacts, but by the quality of the support received.

Different sources provide incongruities in support among various forms of health and wellbeing, according to Segrin and Passalacqua (2010). For instance, young adults seek social support from friends, but social support from families can either add to loneliness and difficulties with social adjustment or can have no effect at all.

Bellman et al. (2003) share additional findings by Cohen and Wills (1985) which suggest that females are more likely to perceive benefits from social support due to their tendency to attain satisfaction from talking about their feelings. Bellman et al. (2003) cite additional research (Cohen, Sherrod, & Clarke, 1986; Coyne & DeLongis, 1986;
Sarason, Sarason, & Shearin, 1986) that shows men may have substandard relational skills and fewer supportive relationships in general.

In the Workplace

Many Americans (54 %) turn to family and friends for support and advice when they have a health problem (Fox, 2011). Individuals who are employed generally have a larger social network and receive more social support (Ruesch, Graf, Meyer, Rossler, & Hell, 2004). Quality of life is higher for those who work outside the home as a result of an enhanced social network and support. While people receive most emotional support from relatives and close friends, co-workers are also shown to be an important source of emotional support. Research by Ruesch et al. (2004) shows that the workplace is a context for establishing and maintaining intimate, instrumental relationships that cannot be easily replaced by other contexts. We first think to look to doctors and nurses for medical advice and information. However, spouses, friends, children, the Internet, and coworkers often can have just as much, if not more, impact on health decisions (du Pre, 2010). The health crisis can be our own, or it can involve a loved one or close friend. In any case, there is a generally a desire on the part of the individual facing the crisis to retain control, not only of the health situation, but also of their life. This can include concerns over employment or team membership. While legislation (U.S. Department of Labor) affords certain employees job-protected leave to care for their own or family members’ serious health condition, the employee may feel concerned that their co-workers and supervisors will be angry if they are not able to pull their weight, due either to absence or to impairment in their ability to function.
According to Eldh and Carlsson (2011), it can be difficult to manage the role of caregiver (if the health crisis involves a loved one or close friend) or patient and employee. The need for support at work includes both being able to take time off without penalty as well as one’s manager and coworkers recognizing the difficulty in managing multiple roles (Eldh & Carlsson, 2011). Further, if the individual has developed a close relationship with those in the workplace, support from the work family may be desired. Eldh and Carlsson (2011) suggest that being supported at the workplace involves understanding by the employer. This is demonstrated by creating a flexible work environment in which the employee is able to complete work at a time that is more convenient. Eldh and Carlsson (2011) also suggest that managers ensure the work unit is staffed properly to allow the employee time off without additional burden on other staff. This same research also showed that employees simply wanted to be able to discuss their experiences, in part so that coworkers can understand the situation and how work performance might be affected. Being able to relate to other human beings is “essential for experiencing health emotionally, spiritually, and physically” (Eldh & Carlsson, 2011, p.291). Rahim (1997) defines social support as “the availability of help in times of need from supervisors, co-workers, family, and friends” (p. 162).

There is ample literature on support in the workplace as it relates to workplace-related stressors. Rahim’s (1997) study on stress in the workplace revealed that managers with high internal locus of control were better able to deal with work-related stress when receiving social support. Research by Cummings et al. (2008) revealed that support for innovation and conflict management among Canadian oncology nurses were predictors of job satisfaction. Mrayyan (2009) compared job stressors and social support between
wards and intensive care units in Jordan. Other studies (Lindholm, Dejin In-Karlsson, Ostergren, & Uden, 2003; Lindorff, 2000) examine workplace stressors that managers face and what influence support has on them. Calcott and Raven (2011) claim that line managers have responsibility for the emotional wellbeing of their teams and the organizational as a whole, but their research was only concerned with support associated with workplace-related issues.

A major finding in Shirey’s (2004) work was that social support from co-workers and supervisors is vital in positively influencing affect, coping, and wellbeing. Shirey adds that the psychological benefit seems to come from access to information, knowledge transfer, and close personal relationships. A second finding showed that hardiness, described as the ability to withstand adverse conditions (Hardy, 2011) can be taught. In 2000, Hendel, Fish, and Aboudi studied 100 female nurses in an Israeli hospital during an Iraqi crisis. The findings revealed that 85% of the nurses demonstrated calmness due to social support (in the forms of information and emotional support) from their nurse managers.

Vananan et al. (2003) argue that workplace culture can be a better predictor of absenteeism than demographic or psychological characteristics of employees. Their study on employee absenteeism that found that along with job characteristics and physical and psychological symptoms, social support was negatively related to the number of resulting absences due to sickness. Research by Taskila and Lindbohm (2007) indicates that general workplace support and accommodations for illness and treatment may play a significant role in cancer survivors’ decisions to continue or quit working. Lindorff’s (2001) study on support available to managers claims that managers should
provide high levels of social support to subordinates, but explains that this could be problematic due to the non-reciprocal nature of the superior-subordinate relationship. The research suggested that managers received more support from non-work sources and the support that was received in the workplace was more in the form of distraction than by expressions of care and consolation (which was provided by non-work sources). All of this research, however, fails to address specifically the role of the leader offering social support in a health context to followers.

While previous research has demonstrated the importance of supportive communication in the workplace, the idea of leaders offering supportive communication to followers in times of the health crisis is largely neglected. Also lacking in previous studies is a conception of how the health crisis is problematic for the leaders. Leaders have a responsibility to both their followers and the organization. For this reason, the health crisis poses different problems for the leader and follower. Before leadership is discussed in more detail, a theoretical framework will be introduced which will tie together supportive communication, leadership and the health crisis.

Problematic Integration – An Introduction to Theoretical Framework

Information pertaining to the health crisis can be troublesome for individuals. Concern of stigmatization, loss of control, and fear of the unknown are just a few examples. The Theory of Problematic Integration (PI) posits that individuals form probabilistic and evaluative orientations to their world (Babrow, 2001). Probabilistic orientations refer to the likelihood that an event will occur, while evaluative orientations categorize something as good or bad. Babrow (2001) asserts that these expectations and evaluations are incorporated in and formed by our experiences. These orientations to a
specified object (in this case, the health crisis) are combined with each other as well as larger constructs of feelings, behavioral intentions, and knowledge. The integration of these probabilistic and evaluative orientations into our world is often problematic. PI theory implies that communication forms our assessment of the world. Communication shapes and reflects probabilistic and evaluative orientations with one another and with related values, attitudes, and intentions. Babrow (2001) explains that problematic integrations are produced, perpetuated, and altered by communication. News of the health crisis can make it challenging for the leader to address both follower and organizational needs. Trying to maintain a strong, encouraging façade when the health situation proves to be especially troubling can create internal dissonance for both leader and follower. Followers may face uncertainty about their prognosis. Moreover, it may be difficult for leaders to provide the same support to members of the in-group as well as the out-group. These are just a few examples of ways that news about the health crisis may be problematic.

Leaders and followers collaborate to meet shared goals; therefore, it is important for open communication to take place in times of health crisis. Problematic integrations can be perpetuated or changed by communication. Individual needs, in conjunction with the needs of those from other cultures, can differ. But social support, as a communication behavior used to offer assistance, can be managed in ways to make the health crisis less problematic for both the leader and follower.

Discussion will now turn to a look at leadership in order to understand what is already known about the responsibilities and characteristics associated with effective leaders.
Leadership

Background

Hackman and Johnson (2009) assert, “Wherever society exists, leadership exists” (p. 5). While managers focus on solving problems using physical resources, leaders are problem finders who focus on spiritual and emotional resources, according to Bennis and Nanus (1985). The lessons that one learns through leadership build values that are essential to success in other areas of life and human relationships (Callahan, 2009). The leader is a source of guidance and inspiration. Federman, as quoted in Hackman and Johnson (2009), says, “This business of making another person feel good in the unspectacular course of his [her] daily comings and goings is, in my view, the very essence of leadership” (p. 61).

Callahan (2008) stresses the importance of adapting leadership styles to meet the needs of different situations and individuals within an organization and asserts that leaders must approach each encounter with attention, intention, decision, and action. Callahan also states that it is imperative for a leader to understand what is going on with followers. Effective leaders motivate by creating a sense of purpose that directs followers to operate with the organizations’ interests in mind (Andreescu & Vito, 2010). While a preference for a certain style may exist, that does not rule out the possibility of an inclination toward another style. However, being a good listener has been correlated with success in all facets of leadership (Hogan, Andrews, Andrews, & Williams, 2011).

Being in charge bears a wide variety of responsibilities and inconvenience, but with it comes the ability to make a substantial impact (Ginsberg, 2008). Leaders are constantly encountering situations that are difficult to traverse. This can require the
leader to present the corporate face, while hiding emotion to appear resilient and assured (Ginsberg, 2008). Understanding emotions has been shown to be an important facet of leadership, and this idea is explored in the next section.

Emotional Intelligence

Sewell (2009) discusses emotional leadership in the military and contends that even army leaders can benefit from a better understanding of their emotions and the emotions of others. Being self-aware, adaptive, flexible, and agile are competencies associated with emotional intelligence, according to Sewell.

Successful leaders are able to anticipate reactions by considering the emotional side of an issue (Feather, 2009). Leaders should be aware of their own feelings in order to correctly identify individual and group emotions. Feather explains that this awareness allows a leader to develop shared organizational values, vision, and expectations.

Caruso and Salovey (2004) say that emotionally intelligent leaders can better make use of emotions by making sure they identify the feelings of all participants (themselves included), and that emotions are used to enhance thinking. Further, an emotionally intelligent leader understands how current feelings may change as a situation progresses and takes emotions into account when making decisions. This suggests that while leaders have a responsibility to their followers, they also have a responsibility to the organization.

Emotionally intelligent leaders are able to match the mood with the problem. Feeling the need to express one set of emotions while internalizing another is problematic for leaders, according to Ginsberg (2008). Leaders must pay attention to the emotions of others and understand them in order to connect with them, according to Hackman and
Johnson (2009). Furthermore, in a multicultural world, instead of relying on predetermined philosophies about how to send and interpret emotional messages, effective leaders seek to learn as much as they can about the sensitivity guidelines of other cultures. Leaders must, according to Hackman and Johnson, mold their communication styles to connect at the level of followers while simultaneously attempting to help followers change how they view themselves.

**Leader/Follower Communication**

In the book, *The Human Side of Leadership: Navigating Emotions at Work,* Ginsberg (2007) asserts that open communication is not only healthy for both leaders and the organization, but is also ethically essential. Further, open communication is a form of support and damage control. Leadership consists of two main communicative dimensions, according to Hackman and Johnson (2009): task and interpersonal. While task-oriented communication pertains to production and structure, interpersonal-oriented communication has been called things like employee-oriented, consideration, and concern for people. The interpersonal leader is concerned with relationships and “emphasizes teamwork, cooperation, and supportive communication” (Hackman & Johnson, 2009, p. 51). Worker-centered leadership adopts a socio-emotional orientation in which the leader expresses concern for followers’ feelings, opinions, and ideas. This approach helps to cultivate a sense of trust between the leaders and followers (Andreescu & Vito, 2010).

Major predictors of job satisfaction are strong leadership and a work-life balance that leads to psychological empowerment (Cummings et al., 2008). When followers are confronted with work-related tasks that cause them difficulty, a leader can make the
situation more bearable by engaging in supportive communication. While followers may have the appropriate skills to perform the task, they may lack confidence or commitment. By using supportive communication, leaders can boost confidence and commitment.

Supportive communication can change the outlook of the employee. It is important for leaders to be consistent in their efforts at social support. Hackman and Johnson (2009) emphasize that followers are persistent watchers of leadership activity, and discrepancies in behavior reveal insincere leadership performances.

The transactional model of human communication is complex and involves negotiation of common interpretation and meaning (Hackman & Johnson, 2009). Hackman and Johnson (2009) say that “leadership effectiveness depends on our willingness to interact with others and on developing effective communication skills” (p. 21). Denning (2005) suggests that leadership is interactive and relies heavily on narrative. Stories reach the heart, enabling leaders to relate themselves to others and develop strong relationships. Additionally, stories can reflect important values and illustrate appropriate behavior.

Previous research has demonstrated the importance of health-related social support to the individual affected by illness. Prior studies have also addressed the importance of supportive communication relating to workplace issues as well as the importance of adaptability and emotional intelligence in leadership. However, there is no existing literature on how leaders utilize supportive communication in times of the health crisis.

While the health crisis is certainly problematic for the follower, it can also be problematic for the leader in several ways: Does the leader have genuine concern for the
follower as an individual? Is the leader concerned with the effect of the health crisis on
the organization? Is there the possibility of a similar situation affecting the leader? Is it a
combination of these? Babrow (2001) contends that probabilistic and evaluative
orientations are combined with each other in addition to larger constructs of feelings,
behavioral intentions, and knowledge. The Problematic Integration theory implies that
communication forms our assessment of the world. Babrow argues that problematic
integrations are produced, perpetuated, and altered by communication. As discussed
earlier, Albrecht and Goldsmith (2003) refer to social support as a communication
behavior as essential to interaction as informing, persuading, or teaching. Considering
social support as a communication behavior used to offer assistance during the health
crisis, the following questions are posed:

RQ 1: How do experienced leaders in a variety of organizational contexts
describe the followers’ health crisis as problematic?

RQ 2: In what ways do leaders offer social support in order to make the health
crisis less problematic for the follower?
CHAPTER III

METHOD

Participants

After approval was obtained from The University of Akron’s Institutional Review Board (Appendix A), participants were selected using a criterion sample. Potential participants were required to have five years leadership experience and currently be in a leadership role or held a leadership role in the past and in a position to offer support. Participants were obtained from a variety of occupational contexts. Each potential participant was directly contacted by telephone or in person by the researcher, who explained the nature of the study. Once the participant agreed to take part in the study, a mutually agreeable time and place was determined to conduct the interview. At the time of the interview, the researcher administered the consent (Appendix B), which explained the purpose, benefits, and risks of the research, as well as other pertinent information.

Leaders were selected from each of the following employment contexts: health care (including one each from nursing and facility repair), the military, and a human resource solution company. One leader had recent experience in both law enforcement and collegiate-level athletics. Education level of the leaders varied, including two having associate degrees, two with bachelor degrees, and one had earned a master’s degree. Leadership experience ranged from 10 years to 40 years, with the average
leadership experience being 21 years. The number of followers ranged from 10 to 150, with an average of 54. To ensure anonymity, leaders are referred to by number, assigned by the order in which they were interviewed. In addition, names of organizations or specific locations are not included. Furthermore, consent forms and any other information relating to the identity of participants will be kept in a locked file cabinet in the School of Communication for a period of one year.

Data Collection

Face-to-face interviews were conducted using an interview guide (Appendix C). These semi-structured interviews contained questions designed to evoke responses that would reveal details of how leaders describe the followers’ health crisis as problematic as well as the different ways in which leaders offer social support in a health context to followers. The interviews ranged from 23 to 41 minutes in length, with an average interview length of 32 minutes. All interviews were audio recorded (with permission) and then transcribed verbatim to assist in the accuracy and analysis of the data.

Data Analysis

Once the interviews were transcribed, they were analyzed using the constant comparison method. Part of Glaser and Strauss’ (1967) grounded theory approach, this method allows categories to “develop through an ongoing process of comparing units of data with each other” (Lindlof & Taylor, 2011, p.250). By performing a line by line analysis of the transcripts, the researcher utilized open coding to categorize portions of data. Repeated examination of the data focused on these categories and by making connections between them (the process of axial coding), themes were created. After the
initial themes were identified, an additional coder, another graduate student in the School of Communication, performed the same line by line analysis and examination to verify accuracy and completeness of the themes.

By using an inductive approach to observe common ideas within the data, a total of seven themes were interpreted which captured the essence of the leaders’ experiences with the followers’ health crisis. These themes will be discussed in detail in the next section.
CHAPTER IV
RESULTS

Interpretation of the data revealed a total of seven themes that captured the leaders’ experiences with the followers’ health crisis. Three of these themes applied to the first research question, investigating how experienced leaders in a variety of organizational contexts describe the followers’ health crisis as problematic. These themes were personal concern, lack of information, and effect on productivity.

Personal Concern

The first theme showed that the health crisis could be problematic to leaders because they were concerned for their followers. Personal concern refers to the compassion and consideration leaders had in viewing the follower as a person, not a subordinate. Leaders wanted followers to know they were still part of the team, even if illness prevented them from participating to the extent they were accustomed to. This concern extended to the individual’s family, and how the health situation would impact them, including potential monetary issues if the employee had to be off work for an extended period of time. All five leaders expressed high levels of compassion for those they led. Four leaders even used the term “family” when describing the leader/follower relationship. Leader 4, a clinical coordinator in a patient care unit at a Midwestern pediatric hospital, stopped short of calling her followers family, but did refer to a “strong bond” and members of the work unit “having your back.” She described today’s work
environment like this: “We need to get back more like the mom and pop shops where they care about you and if you’re sick, they’re going to take care of you and ‘don’t worry, we’ll see what we can do’.”

Leader 1, an owner of a human resources solution company, said when he finds out an employee or family member is sick, he instantly wonders if there is anything he can do to help: “…I have… a lot of empathy. So, um, I immediately sort of want to help. I just ask what I can do.”

Leader 2, Director of Engineering and Facility Repair at the same Midwestern pediatric hospital as Leader 4, described his concern as well: “Every time I hear of a health issue kind of situation going on, I always keep them in my prayers, my thoughts.”

Feeling concern for people and wanting to help them is just something people should do, according to Leader 4, who said, “I just think that’s what we’re here for. We’re here to help each other and if you can’t do that, then I think there’s something wrong with you.” Leader 5, a recently retired assistant police chief of a large Midwestern university as well as their rifle team coach, felt similarly: “I’m of the belief that if somebody needs help, I think we as humans are just obligated to, within our means, try and help.”

Lack of Information

The second theme that emerged as being problematic was lack of information about the health crisis. Both the leader and the follower could be impacted by this. A follower may be unaware of workplace procedures that need to be followed, or they may require information in regard to how to seek help for their health issue. Most times, individuals were able to discern when they needed to see a medical doctor, but when a
follower had a substance abuse issue, this could require a type of assistance that they were unfamiliar with. A leader, obligated to comply with HIPAA regulations, often lacked information about the health crisis. All five leaders spoke of the limitations that HIPAA imposed on their ability to obtain information. If the follower was unwilling to share information, the leader was unable to determine the extent of the illness or establish if a follower was abiding by some sort of prescribed regimen intended to improve the health condition. Furthermore, there may be times in which a leader was unaware a problem even existed. These situations made it difficult to foresee staffing shortages or anticipate follower needs. Leader 1 revealed that when he first finds out someone is sick, his first question to himself is, just how sick is that person.

Lack of information can also refer to the health crisis creating situations that the leader had never been exposed to, therefore leaving them unsure how to proceed. This is in line with Ginsberg’s (2008) assertion that leaders are constantly encountering situations that are difficult to traverse. Leaders 3 and 5 both mentioned that a health crisis could put the leader in this position. Leaders recognized that they needed to become involved and accept new tasks associated with the followers’ health crisis rather than ignore the situation or pass the responsibility along to someone else. According to Leader 3, a Master Sergeant at an Air Force base in the southern United States: “As a leader, that’s one thing you have to do is take care of your people, and that means sometimes doing things you’re not accustomed to.” Leader 5 shared a story in which he and the rest of the police department leadership were unsure how to proceed with an officer who was pregnant:

Including myself, we didn’t know what to do…and within our administration, there was a wide range of we can’t let her work, we could let her work…so we
debacle[d sic] that back and forth to where we gave her good support. We gave her no support, and I felt bad for her because she even said, ‘I don’t know from week to week what you guys are gonna do’ and I ended up having to tell her, ‘I don’t know from week to week what we’re gonna do’.

Leader 4 provided a description of the health crisis: “A health crisis is something that’s out of the norm that throws you out of what you normally are comfortable with and puts you more into a state of unrest, undeciding. That you’re not functioning as your normal self.” Lack of information, whether it involved details of the health crisis or uncertainty as to how to proceed, contributed to this state of unrest.

**Effect on Productivity**

When followers have a health issue that requires time away from work, it can mean additional effort for staff and have an impact on team efficiency. Therefore, the third theme making the health crisis problematic for leaders is the effect on productivity. Three of the interviews revealed accounts describing the employee absence as challenging. While leaders have a responsibility to their followers, they also have a responsibility to the organization. This pertains to what Hackman and Johnson (2009) call task-oriented leadership, which deals with production and structure. However, the interpersonal leader is concerned with teamwork, cooperation, and supportive communication. Effect on productivity refers to a situation in which the employee is absent from work or otherwise unable to do his or her job in the capacity expected, and leads to a change in the efficiency of the work flow of the unit or team. The leader must find a balance between structure and support. Leaders have the ability to instill trust in their followers, and can overcome resistance to change by building confidence and empowering employees to seek out new ways of doing things (Bennis & Nanus, 1985).

Leader 3 described absenteeism from a military perspective:
If you’re not qualified and you can’t go do things because you always have some kind of issue, well then now you’re getting paid but you’re not doing what you’re getting paid to do and that’s to be able to go out and do your job 24/7. If someone isn’t there due to something health-wise, then someone has to pull their slack or pull their weight…And that’s a problem because they’re not there to do what they’re supposed to do and somebody else has to do that job and their own.

Leader 5 explained that followers are investments, and as employers, that investment needs protected: “We need this person to get well enough to come back and provide a service…” Leader 4 said that the employee absence would impact the unit, resulting in less staff to take care of patients, and said that it is important to consider how to help that individual while making staff-related adjustments if necessary.

The second research question in this study asked: In what ways do leaders offer social support in order to make the health crisis less problematic for the follower? Interpretation of the leaders’ descriptions of the health crisis revealed four themes. Support is offered unconditionally, with flexibility, voluntarily, and is provided through multiple channels, including emotional, informational, and tangible.

Unconditional Support

Unconditional support means offering support to every follower, every time. According to all five leaders, support can’t only be offered conveniently or preferentially. As Hackman and Johnson (2009) assert, followers are persistent watchers of leadership activity. Any inconsistencies in support would be quickly identified. Even if a follower was not a member of the in-group, support was still offered by the leader. In some instances, this unwavering support was required by the organization. But support was seen as a way to create and maintain team morale. Offering support helped not only the individual in need by providing pieces to put the puzzle of the health crisis together, but each leader felt that support also improved self-esteem, which led to a better work
environment, and in turn, better relationships. Leader 1 used a quote from the movie “Jerry Maguire” to articulate his view:

He had that mentor who showed up every once in a while in the movie, Dicky Fox was his name, and he said at one point, ‘If you don’t love everybody, you can’t sell anybody’ and I think that’s really true because people know when you’re situational, and they know when you really care or you don’t.”

Leader 3 expressed a similar view, though matters of national security may pose a particularly salient issue:

You kind of have to be there to support your people, whether you like them or not, because you need every individual that’s in that shop. And you don’t know when you’re gonna have to go work with them side by side for four months in the desert and they may have to save your life.

Flexibility in Support

Being able to provide flexibility in support was important for each leader, as discovered through their explanations of the health crisis. Though leaders recognized the importance of a fully staffed workforce or team, they also recognized the importance of flexibility. Flexibility refers to the ability and willingness of the leader to adapt in whatever capacity necessary in order to meet the needs of the situation. These changes could take place in the form of work schedules, work duties, or the type of support offered. Leaders mentioned that one supportive approach does not fit all, and different circumstances require different supportive tactics. This relates to work by Chamberlin-Quinlisk (2007), who said adaptability is a communicative resource. Moreover, Callahan (2008) addressed the importance of adapting leadership styles to meet the needs of different situations and individuals. Sewell (2009) asserts that flexibility is a skill associated with emotional intelligence, which is considered to be more important to success in life than traditional IQ.
The nature of the business that Leader 1 works in allows him to permit employees to work from home if they are ill, or they can just take time off if that is what they require. Leader 2 talked about the importance of working around schedules so that employee needs could be met: “I’m very, very flexible with those kind of things. I know I’m probably violating some of the policies in the hospital by doing that...”

Another type of flexibility involves the level of support given. Leader 3 explained that some airmen don’t want a leader to be emotionally supportive. Some just need to vent or express frustration, but do not need anything in return other than just someone to listen. Others are newer to the Air Force and are unsure of processes, so he explained his approach on these different situations:

Everybody wants something different from you and you have to adapt. They all want something, but you have to know how to get to them to make them feel better...you have to be a jack-of-all-trades. You really have to take every single incident and separate it ‘cause none of them are the same.

Leader 4 said that sometimes it might be necessary to bend the rules in order to prevent someone in need from getting hurt. While she wouldn’t do something detrimental to the organization, she believed that often times company guidelines could be overlooked and different approaches taken, and as a leader, it’s important to recognize that. Leader 5 echoed her attitude as he offered the following response:

“I get really frustrated when I hear the University or my chief or something say, ‘Go over the policy to see how we’re gonna deal with someone who is hurt’. I don’t think you can because I think you need to look at that person, and develop a policy for that situation.”

Voluntary Support

Leaders don’t wait to be asked for help. They adopt a proactive approach to offering social support. Three of the five leaders discussed voluntary support as being significant
in their dealings with followers. Voluntary support means that the leader chooses to offer support without any urging or request from the follower. The value of this approach is that followers feel a sense of worth when unsolicited kindness or consideration is shown toward them. Making people feel good is the very essence of leadership, according to Federman (as cited in Hackman and Johnson, 2009). By paying attention to the emotions of followers, leaders are better able to relate to them and anticipate needs. Leader 1 explained that he doesn’t just throw out a generic offer of assistance and then wait for the follower to request something specific. He will collaborate with other members of the team, if appropriate, to determine what can be done to assist the person in need. He described how he accomplished this: “I might brainstorm with Mallory and say, ‘here’s the situation.’ Like, I guess, similar to, you can ask your neighbor after a surgery if she’s okay, or you can make her dinner and bring it over and just surprise her.”

Leader 4 talked about how she tried to anticipate individuals’ needs for information pertaining to requesting time off work: “Give them that, so they don’t have to ask you. You kind of give them the information.”

While HIPAA regulations affected the degree to which a leader could discuss health-related issues with followers, each leader responded that if they became aware of a problem, they would approach that person and inquire about their general wellbeing. This expression of concern may help offset any perception on the part of the follower that a workplace support system does not exist. If the follower was willing to reveal the nature of the problem, the leader would listen and offer whatever support may be appropriate. But the leader would not, neither legally nor morally, infringe on someone’s right to privacy.
Channels of Support

The fourth way leaders offered support was through multiple channels. These include emotional-based support, informational support, and tangible support. Emotional-based support includes providing an individual with a sense of value by expressions of concern and acceptance. Whether continuing to include the follower in team activities or just lending an ear, all five leaders recognized the worth of expressing concern. In addition to expressing concern, emotional support also meant mentally preparing a follower to return to work after time off. Perhaps the most profound application of emotional-based support that the leaders revealed was preparing the employee or athlete for the realization that they could not return to the team in the capacity to which they were accustomed, if at all.

This use of emotional assistance is supported by Albrecht and Goldsmith (2003), who said that increasing a person’s sense of control may very well be the main function of social support. Leader 3 talked about the different ways he’s offered emotional support to followers and why it’s important:

I mean, you got these tough guys that don’t want you to be emotionally supportive. Some people just kind of come in and they vent and they leave…I think it’s important to give encouragement and be there for folks, because they remember. I may not remember everything I said to 60 people, but that individual remembers.

Leader 4 offered this account about a co-worker’s funeral:

Everybody was coming in their own car and some of us came together and there was one of the newer girls who wasn’t really part of the group. Everybody else was leaving the parking lot, going to the next place for us to meet at, and I just stopped and pulled my window down and said, ‘Hey, do you want to come with me?’ It was like that girl was gonna jump in the car. Just profuse ‘Thank you! Thank you!’

Leader 5 described how the rifle team will gather around an injured teammate:

“The team members will gather around the family and say, ‘Well, you can’t shoot, but
you can still do pizza with us, or come over to the house and watch SpongeBob and you know, you’re still part of the team. You’re still part of the family.” The same leader also explained how illness or injury may prevent an individual from coming back to work on the police force or to the rifle team in the capacity they were accustomed to, if at all: "It’s situational to where it may physically, allow them to come back and be able to do the job. Mentally prepare them to do that. Or mentally prepare them for the fact that you're not gonna recover from this. You're gonna have to choose another path.”

The next channel of social support was that of information. This refers to the provision of advice and information. Whether guiding a new employee through the process of requesting time off or providing a follower with resources that may help with the health crisis, four out of the five leaders discussed that as a source of knowledge about workplace procedures, it was important to pass this information along. Information is often seen as power, and when a follower has cues as to how to proceed, he or she can feel empowered, acting to increase one’s sense of control in otherwise uncertain times.

Leader 2 explained how he educates followers about resources offered by the workplace:

We've actually had some who have had some severe addiction problems that I've recommended that they, we have a psychological service, uh, that's provided by the hospital free to employees that they can go to talk to a counselor about virtually anything that's bothering them...they can seek that help, and I always recommend that to them.

Leader 3 described that the experience level of the airman at times requires an informational approach to support:

You know, I don't have to sit there with a guy who's been there for 15 years and tell them what they need to do to make themselves better...you've got airmen who don't know anything because they just came in, and you have to guide them through the process. So it depends on really the age of the individual, how long they have been in the military, what is their experience level, 'cause these airmen don’t know.

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Leader 4 also illustrated the use of sharing information to benefit followers:

“...Now you've told me what's wrong, you need to take time off. This is what you might have to do. This is where you need to go; this is who you have to tell.”

Leaders described several different ways in which they offer tangible assistance, the final channel through which support is provided. Tangible support includes taking action and physically assisting someone in need. Four of the interviews revealed the ways in which this type of support was offered to followers. Leader 4 discussed helping provide transportation for a follower’s child’s activities, washing dishes and scrubbing floors, and bringing meals over. Leaders 2 and 5 both described making different kinds of appointments for individuals, if they request it. Additionally, Leader 5 said when an athlete is injured, he makes sure that individual is able to get back and forth to classes, even contacting the campus accessibility office if necessary.

Furthermore, Leader 1 mentioned providing gift cards to restaurants, and “looking deeper to see if there is something, like if they’re having financial problems…” Leader 5 discussed monetary assistance as something not only leaders do, but also that a workplace family provides. An injured officer may be newer to the force and doesn’t have a lot of sick leave, and that can mean the majority of his or her time off without pay. But leaders ask:

What are they gonna go? They’ve got three kids, and a wife or a husband. What’s their source of income? The next thing you know, everybody’s getting their paychecks and kicking in a hundred bucks a pay. They’ve got car payments, house payments, and we need to make sure that they’re gonna get through this.
CHAPTER V
DISCUSSION

The purpose of this study was to examine the ways in which the followers’ health crises are troubling for leaders and how leaders engage in social support communication to make the crisis less problematic for the follower. The theory of problematic integration suggests that probabilistic and evaluative orientations to an object (the health crisis) combine with individual experiences, and integrating these orientations into our world can be problematic.

If leaders did not specifically use the word “family” to describe the leader/follower relationship (as four of them did), other words and phrases were used, such as “bond”, “having your back”, and “going the extra mile”, that expressed the strength of the connection between leader and follower. Each leader talked about how having an authentic concern for followers led to better morale within the team. Leader 3 explained how having a natural concern for people helped build team confidence:

So if people think I care, you know, about their well being and their families, that I take the time to even know the names of their wives and their kids, they’re gonna want to work for me because they trust me. If they feel like I don’t care anything about their well being, well who wants to work in that environment?

Leader 2 agreed: “They seem to be more happy because they know I’m not some dictator sitting here…I think it makes for a comfortable, friendlier work atmosphere.”
Therefore, finding out a “family” member is ill is concerning for all, and the leader can facilitate a supportive setting in which the follower can feel valued.

Lack of information was another area of difficulty. A leader asked questions like, “How serious is the health crisis?” and “How do I proceed?” Leaders admitted that extreme situations called for action outside of the course of one’s daily functions. Leaders also recognized the need to admit their shortcomings in this area and understood how their uncertainty and lack of knowledge may add (although it may be unintentional) to the crisis.

HIPAA regulations were seen as a double-edged sword; necessary to protect an individual’s privacy, but counter-productive to concerned leaders unsure of and wanting to express concern and inquire about a followers’ condition.

Leaders, as part of their responsibility to balance management with leadership, also saw the health crisis as problematic because it could potentially affect productivity. Other team members are required to acquire the burden of the duties of the employee who is absent or not able to perform the job to their full ability. This had the potential to lead to unhappy team members and decreased team morale. Eldh and Carlsson (2011) suggest that sometimes employees want to discuss their health experience, in part so coworkers can understand the situation and how performance may be affected. But there are those employees who are not likely to disclose information of a personal nature. By providing support in a consistent manner across situations and among individuals, leaders have the ability to foster a collaborative environment in which other workers or teammates are willing to shoulder the additional load left by others.
Follower absenteeism was more significant in some contexts than in others. For example, when an individual cannot participate in an athletic event, it is rarely a matter of life and death, but it very well could be for a patient in a poorly staffed unit, or for an airman in battle. Regardless of the context, followers are an investment, and it is natural to expect a positive return on that investment.

The second focus of this study was to investigate the ways leaders communicated support to followers in order to make the health crisis less problematic. Four themes emerged from that analysis.

The first theme, unconditional support, is representative of the importance of a leader’s ability to be consistent. Interviews with all five leaders exposed the connection they had with their team, likely a result of consistent, positive, leadership behavior. Hackman and Johnson stress that consistency is a challenge for leaders, but unbiased conduct with followers should be the rule, and exceptions should be made after careful thought. These decisions can be guided by understanding ethical behavior and widely accepted ethical perspectives.

Being flexible was the second way in which leaders described engaging in support communication with followers. Some leaders noted the ability to be flexible with work schedules so that followers could, for example, have time off to recover, or perhaps provide transportation to a doctor appointment for a family member. Individual needs vary, and flexibility is a characteristic that is essential to leaders and enables them to address these needs accordingly.

Voluntary offering of support was the third theme. If leaders were aware there was some sort of health issue with a follower, they wanted to reach out to help. Being an
effective leader is dependent on one’s willingness to cooperate with others and the
development of effective communication skills, according to Hackman and
Johnson (2009). Each leader expressed knowing that HIPAA regulations limited the
amount of questions that could be asked, and if a follower did not disclose information
upon a general show of concern from the leader or if the follower appeared to be
uncomfortable in any way, the leader did not force the issue. A leader would tell
followers that his or her door is always open, so the offer of support was there should the
follower choose to utilize it. With the limitations HIPAA imposes, followers may not be
aware that leaders possess a genuine concern.

Fourth among the themes that emerged was that support is offered through
different channels, the first of which is emotional-based support. This type of support
provides the follower with a sense of value, and contributes to self-esteem and emotions.
Leaders should make sure they recognize how valuable support is to followers.

The second channel used to offer support was informational. Since leaders and
followers work together toward the shared goal of making the health crisis the least
problematic for both parties, it only made sense to share information that enabled the
employee to better handle the health crisis and return to a productive role.

The third and final channel that emerged from the research was that of tangible
support. This could include making appointments for followers, cleaning one’s
home, running errands, providing meals, or even monetary support. These actions
indicate that the follower is more than a subordinate, someone in a lower class, subject to
the authority of the leader. The follower is someone who the leader knows, likes, and
trusts, and together, they are allied in a cause; that is, making the health crisis less
problematic. According to Webster’s New College Dictionary (2005), that is the definition of a friend.

While managers mobilize others by organizing and staffing, leaders rally others by focusing on teamwork and loyalty (Hackman & Johnson, 2009). Conveying interest in or concern about a follower leads to trust and a general sense of happiness, which can result in a strong workforce. Leader 5 viewed social support as a type of recruitment tool. He described the follower as an ambassador who would spread the word about how well a department or organization took care of its people. This, he said, builds a desire for highly trained, professional people who wanted to be a part of that particular team.

Further, a follower may be more likely to stay in a current position as opposed to moving on for more pay because of the consideration he or she received. Moreover, offering support was the ethical thing to do as well as an act of professionalism. Professionally, the employee or athlete would be more likely to give a leader their best performance, and ethically, a fellow human being saw that another needed help and provided it. No matter how respondents described a leader (visionary, motivator, listener, opportunity-provider, problem-solver, or task-overseer), each said that providing support to employees was crucial. As Ginsberg (2008) suggests, being in charge bears a wide variety of responsibilities and inconvenience, but with it comes the ability to make a substantial impact. Showing support helped the individual by, as Leader 4 said, giving that person the different pieces they need to handle what is going on, and the more support one has, the easier it is for them to deal with their issues. Leader 2 explained that just knowing that someone cared was a benefit for the individual, and Leader 3 emphasized that by taking the time to let people you know you care resulted in happy employees, which
fostered a mutual respect between leader and follower; the ultimate goal. Having satisfied employees led to better morale, better work environments, and better productivity, which all benefit the organization. Leaders also benefitted from offering support. When a leader took the time to listen to employees, it resulted in support for that leader; such the same as “having my back” that both Leaders 3 and 4 referred to.

From the leaders’ descriptions of the health crisis, some important issues were discovered. One revelation was the amount of genuine compassion that each leader expressed for the follower. While it was expected that organizational norms would require leaders to offer support to a certain extent, leaders were truly concerned with the wellbeing of their team members. This highlights differences between managers and leaders in two ways; not only do leaders view their followers more as equals than subordinates, they are also able to balance organizational and individual needs to result in the best possible outcome for everyone involved. Followers may not be aware this level of concern exists, and effective communication is important to reinforce this characteristic of leadership.

A second finding of particular interest was the part that social support played in creating team morale. Whereas it has been demonstrated that social support benefits the individual by providing them with a sense of worth and value, the increase in self-esteem extends to the entire team. When team members see that they are cared for, they are happy and it makes for a more productive team, which benefits the organization as a whole. In turn, this leads to a type of recruitment tool for the organization. When content followers express their satisfaction to others, it can result in a word-of-mouth type of advertising that cannot be matched by an ad in the newspaper. Therefore, while
managers are focused on organizational tasks and maintenance, leaders take a few extra minutes to show an interest in their followers, which could benefit the organization more in the long run.

The final point of interest to be addressed from the findings is the wide range of support that leaders are willing to offer. It was anticipated that leaders would be required to provide an offering of general support, more in relation to helping the follower return to a productive role, but leaders were willing to help followers in any way possible. Leaders can mobilize the team to help the individual meet financial obligations or simply assist them with daily activities that have become overwhelming. The willingness and flexibility of leaders to deliver support may not be well known to followers. So it is essential that the lines of communication are open between leaders and followers. HIPAA regulations prevent the amount of inquiry the leader can engage in, potentially leaving the follower with a sense of neglect or rejection. It appears that the follower has a stronger support system than they may realize.

Bennis and Nanus (1985) assert that multiple interpretations of leadership exist, but each remains “incomplete or wholly adequate” (p. 4). The current research helps address this by adding another dimension to what we already know about leadership. And while definitions of concepts like leadership and social support sometimes include buzz words and are reflective of current trends, helping those in moments of need is an attribute that is timeless, and thus is the nature of leadership.

Study Limitations

While this study has sought to expand the knowledge of leadership communication of social support, it is not without limitations. First, while interviewing
and transcribing is not a matter to be taken lightly, the number of respondents (five) is modest. Additionally, all of the leaders who participated were Caucasian and each had at least 10 years of leadership experience. Furthermore, there was no leader younger than the late 30s. Moreover, the majority (four) of the leaders interviewed were men.

Areas of future research could consist of including leaders with less experience and younger in age. Integrating more women leaders into future research may also render different perspectives. In addition, incorporating leaders from other racial, ethnic, or cultural backgrounds could provide new insights into how social support is communicated. Along the same vein, questions could be included in future interview guides to investigate if there is a difference in the way those of diverse races, ethnicities or cultures, request social support.

Another potential area of further study could be to conduct this research obtaining a follower’s perspective about the ways leaders engage in social support communication. It is also unclear if the number of followers on a team has any effect on the type of social support offered or the ways in which news of the health crisis is problematic. Investigating how support was offered before HIPAA regulations went into effect may provide a unique viewpoint. Finally, with the increase in the aging population in the United States, future studies could investigate shifts in the number of followers requiring social support and how leadership perspectives and support may differ because of the potential increase.

Concluding Remarks

This study represents a fundamental attempt to investigate the ways leaders in a variety of employment contexts offer social support to followers and how the followers’
health crisis is viewed as problematic. While there are limitations, this research does contribute to existing knowledge on effective leadership and social support in the workplace. Offering social support benefits everyone involved, leading to greater workplace satisfaction. The information gained from this research could be incorporated into leadership training programs and provide a foundation for researchers interested in studying the same topic ideas.
REFERENCES


APPENDICES
APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

NOTICE OF APPROVAL

December 15, 2011
Stafni M. Fee
54 Briarwood Drive
Doyles-town, Ohio 44230

From: Sharon McWhorter, IRB Administrator
Re: IRB Number 201111207 “Leadership Perspectives on Offering Social Support: Problematic Integration and Health Crisis”

Thank you for submitting your IRB Application for Review of Research Involving Human Subjects for the referenced project. Your application was approved on December 15, 2011. Your protocol represents minimal risk to subjects and matches the following general category for exemption:

☐ Exemption 1 - Research conducted in established or commonly accepted educational settings, involving normal educational practices.

☒ Exemption 2 - Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior.

☐ Exemption 3 - Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior not exempt under category 2, but subjects are elected or appointed public officials or candidates for public office.

☐ Exemption 4 - Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens.

☐ Exemption 5 - Research and demonstration projects conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine public programs or benefits.

☐ Exemption 6 - Taste and food quality evaluation and consumer acceptance studies.

Annual continuation applications are not required for exempt projects. If you make changes to the study’s design or procedures that increase the risk to subjects or include activities that do not fall within the approved exemption category, please contact me to discuss whether or not a new application must be submitted. Any such changes or modifications must be reviewed and approved by the IRB prior to implementation.

Please retain this letter for your files. This office will hold your exemption application for a period of three years from the approval date. If you wish to continue this protocol beyond this period, you will need to submit another Exemption Request. If the research is being conducted for a master’s thesis or doctoral dissertation, the student must file a copy of this letter with the thesis or dissertation.

Cc: Carolyn Anderson - Advisor
Cc: Stephanie Woods - IRB Chair

☒ Approved consent form/s enclosed

Office of Research Services and Sponsored Programs
Akron, OH 44325-2102
330-972-7666 • 330-972-6281 Fax
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APPENDIX B

CONSENT

Consent to Participate in a Research Study:
Leadership and Health-Related Social Support Communication

You are invited to take part in a research study conducted by Stefani Fee, a graduate student in the School of Communication at The University of Akron. This research is being conducted under the supervision of Dr. Carolyn Anderson, Professor of Communication at The University of Akron. The objective of this study is to investigate what communicative techniques leaders employ when dealing with a health crisis affecting a follower and why these techniques are chosen. The goal of this research is to identify how the health crisis is described as problematic and ways in which leaders communicate to make information of the health crisis less problematic. You are being included in the study because you have specific, recent knowledge of leadership and have had experience dealing with a follower’s health issue.

Your involvement in this study will consist primarily of a face-to-face interview and will take approximately 30 to 45 minutes. With your permission, the interview will be recorded with a digital voice recorder to aid in the accuracy of the study. All interview questions are related to your leadership experience and how that experience pertains to your use of communication to navigate the follower’s health crisis. All participation is completely voluntary and you do not have to answer any questions with which you are uncomfortable. Furthermore, you may choose to end the interview at any time and for any reason. In addition to the initial interview, you may be contacted with follow-up questions and/or concerns that arise as the study progresses. Again, your involvement in such follow-up efforts is completely voluntary and you may respond in any capacity with which you feel comfortable.

There are no costs associated with participating in the study, nor are there any perceived risks. In addition, there is no tangible reward offered in association with participation in this study. However, your time and effort in contributing to the study are greatly appreciated.

Reports resulting from this study will not identify you as a participant, nor are you required to reveal the identity of the follower you are discussing.

If you have any questions, concerns, suggestions, or complaints about the study, you may contact Stefani Fee at 330-607-3485 or write her at sgavel@zips.uakron.edu or 54 Briarwood Drive, Doylestown, OH 44230. You may also contact Dr. Carolyn Anderson at 330-972-6218, or write her at canders@uakron.edu or The University of Akron, School of Communication, Kolbe Hall 110E, Akron, OH 44325-1003. You may also contact the Institutional Review Board, Office of Research Services at The University of Akron by calling 330-972-7666 with questions about your rights as a volunteer in this study. You may keep a copy of this consent for future reference.

Please indicate your agreement to participate in this study as explained above by signing below:

__________________________________________  __________________________
Signature of person agreeing to take part in the study  Date

University of Akron

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APPENDIX C

INTERVIEW GUIDE

1. What is the highest level of education you’ve obtained?

2. What other leadership training do you have?

3. How long have you been a leader?

4. How long have you been in your current leadership position?

5. How many people do you lead?

6. Do you regularly encounter all of your followers face-to-face?

7. How many followers do you interact with on a daily basis?

8. How do you describe a leader?

9. What are expectations of leaders in your field?

10. What do you believe your role is to your followers?

11. How do you describe a health crisis?

12. What is a typical health crisis your followers might experience?

13. Have you experienced some sort of health crisis which required modification in your work duties or attendance?

14. Has someone close to you (family, friend) experienced some sort of health crisis which required modification in their work duties or attendance?

15. What are your initial thoughts or concerns when you find out an employee or their family member is sick?

16. Is support important? If so, do you offer it?

17. If you do offer support, why do you do it?
18. How do you offer support to followers?

19. Describe any differences in the level of support offered to followers?

20. Have you ever withdrawn an offer of support?

21. Have you ever quit providing support?

22. What have you learned from offering support?

23. What have you learned from not offering support?

24. Can you describe a time when you felt you offered support effectively?

25. Can you describe a time when you felt you were less effective in offering support?

26. If someone is dealing with a health issue and you find out through someone else, how do you approach the situation?

27. How does offering support benefit you personally?
   
   The work unit, department, etc?
   
   The organization?
   
   The individual?

28. Just to review, HIPAA is the Health Insurance Portability and Accountability Act and restricts how health information can be shared. Has HIPAA had any effect on if/how you offer support?

29. What effect do organizational insurance costs and regulations have on promoting involvement in good health practices?

30. Is there anything else you’d like to add?