2021

# Coping with Death, Quality of Life, and Compassion Fatigue Among Hospice Social Workers

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Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Social Work



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Abstract

Research indicates that working with dying patients and their families could cause emotional reactions that not only affect their well-being but their quality of life and desire to continue in their profession. Although researchers have examined compassion fatigue among other professionals, there is a gap in research on the phenomenon among hospice social workers. The purpose of this generic qualitative study was to obtain a richer understanding about how hospice social workers cope with death, what their experiences are with compassion fatigue, and how their quality of life is impacted by their work. The conceptual framework was the transactional theory of stress and coping, which views stress as a transactional relationship between the person and the environment. Eight hospice social workers in the North Florida area of the United States participated in semistructured interviews. Participants were selected using purposive sampling. Content analysis of interview data included coding to summarize or condense the data into seven themes: experiences are influenced by the setting and length of the relationship, maintaining boundaries and acknowledgment of being a job helps with coping, personal losses impact their grief, religious beliefs and faith plays a significant role in coping, there are positive factors in how the job impacts their quality of life, there are also negative factors and compassion fatigue is relatable. The perspectives of social workers who work in hospice care may provide insight on practice approaches to better respond to their needs. With this knowledge, social work leaders may be better able to implement responsive self-care approaches that might mitigate the secondary trauma experienced by hospice social workers and keep these valued professionals in the profession.

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Dedication

This work is dedicated to my husband, Omar Dominguez, and my son, Jose. I could not have done this without your support. Thank you for allowing me the time and space that I needed to complete this work amid many life changes and trials. Omar, for listening to me and celebrating my milestones with me; you always believe in me way more than I believe on myself. I could not ask for a better husband; thank you for taking this journey with me and supporting me. Jose, for understanding; I hope one day you realize that if I was able to do this, you can do anything. I love you guys more than you will ever know, and I thank God for you every day.

I also want to dedicate this work to my grandparents/parents, Felix Rosa and Cecilia Gonzalez. For teaching me that no matter the circumstances never give up, dream big, and work hard. When a master's degree was a crazy idea, they supported me and saw me graduate with pride; after all, I was the first one accomplishing that milestone. Now, I wish you guys were here to see your daughter graduate with a PhD and become the first doctor in the family. I am sure you will be smiling and celebrating in heaven.

Acknowledgments

First, I give thanks to God who made this possible and placed the right mentors to work with me, encourage me, and support me during this process. I am forever grateful to Dr. Kenneth Larimore, my committee chair, for his support, availability, and encouragement during this process. A special thank you to Dr. Sean Hogan, my committee member, for your support and availability. Words cannot express my gratitude to have both of you believe in my research topic and guide me through this process.

Thanks to my beautiful friend Janice Carrico for taking the time to help me with proofreading and encouragement. I thank God for you and your family.

Thanks to my husband and son for understanding and supporting me. Thank you, Blanca Figueroa and Rene Rivera, for always asking about my progress and encouraging me along the way. Thank you to friends and family who cared enough to check in on my progress throughout the years and encourage me.

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Chapter 1: Introduction to the Study

Hospice work can be professionally and personally rewarding; however, caring for the terminally ill can expose social workers to personal challenges. Working with end-of-life and death daily can be emotionally challenging and strenuous. Hospice social workers are trained to empathize with the losses of their patients and families. As they work with this population, they are reminded daily of the fragility of life (Slocum-Gori et al., 2011). Because of the nature of the hospice program, a patient and their family can be served for periods of time ranging from hours or days to several months or a year depending on the nature of the disease and the disease progression and the timing of the referral. This means that the hospice social worker could potentially be working with the patient and their family for as little as a few days or greater than 6 months, which could create a stronger professional relationship or attachment, and the loss of the patient could have a profound impact on the hospice social worker; perhaps the worker could experience grief of losing the patient and their family.

Compassion fatigue, also called *secondary traumatic stress* or *vicarious trauma,* is an individual empathic response to the suffering of patients and their traumas (Alkema et al., 2008). Joinson (1992, as cited in Hoffman et al., 2007) described compassion fatigue as a "unique form of burnout directly related to the caregiving professions" (p. 17). Bride and Figley (2007) described compassion fatigue as an "unwanted effect while working with people who are suffering" (p. 152). According to Strom-Gottfried and Mowbray (2006), compassion fatigue is the emotional distress that helping professionals feel from overexposure to their clients' traumatic events (see also Hoffman et al., 2007).

Compassion fatigue is a direct result of the empathy and emotional investment of the helping professional, according to Strom-Gottfried and Mowbray (2006); the professional can still carry on their work, but the quality of the work may be compromised. Gentry and Dietz (2020) further described compassion fatigue as recognizable exhaustion that includes all aspects of life. Figley (2002) suggested that compassion fatigue is a secondary traumatic stress experienced by helping professionals resulting from "helping or wanting to help a traumatized or suffering person" (p. 1435) that reduces "our capacity or our interest in hearing the suffering of others" (p. 1434) and is difficult to anticipate. Yet, Figley stated that compassion fatigue is highly treatable once recognized and acted upon accordingly.

The literature review shows that compassion fatigue can present in different forms, and, although not all might experience compassion fatigue, it is still a possibility due to the nature of the caring profession. As Sardiwalla et al. (2007) noted, the helping professions have always been associated with high-stress levels. The professionals providing care can feel feelings of regret, anger, and hopelessness (Strom-Gottfried & Mowbray, 2006). Sansó et al. (2015) found that the "ability to cope with death is positively related to compassion satisfaction and negatively related to burnout and compassion fatigue" (p. 205). Alkema et al. (2008) found a relationship between self-care strategies and lower levels of compassion fatigue, burnout, and higher levels of compassion satisfaction.

Increasing the knowledge on how hospice social workers cope, manage their emotions, and experience compassion fatigue and how their quality of life is affected

while working with the terminally ill, the dying, and their families daily will provide a different perspective that could enhance these professionals' work with the dying and their families. Other professions that are in a similar line of work may benefit from the findings of the study. In addition, this study provides insight regarding hospice social workers' perceived needs and how supervisors and administrators might support them in a meaningful way. The study also provides insight regarding participating professionals' thoughts about leaving their careers because of the job demands and their experiences with compassion fatigue.

This addition to the current knowledge may provide guidance for developers of future educational programs targeted to hospice social workers. The study findings could shape the future of educational programs that assist social workers who are starting their careers and are interested in working with the terminally ill. In this chapter, I review why compassion fatigue, coping with death, and clinician's quality of life was an important subject to research. I also present the study's research questions (RQs), conceptual framework, and the methodological approach. Last, key conceptual definitions are included in this chapter, along with discussion of the limitations of the research and its significance to the field of social work.

**Background**

There is a significant amount of quantitative research on compassion fatigue, burnout, and compassion satisfaction, including a number of studies that are hospice worker-related (e.g., Alkema, et al., 2008, O'Mahony, et al., 2018; Sansó, et al., 2015; Sardiwalla, 2007; Slocum-Gori, et al., 2011). However, most are inclusive of all

vocations, such as volunteers, chaplains, doctors, and nurses. There is limited literature that provides an exclusive qualitative focus on hospice social workers coping with death, compassion fatigue, and their quality of life, and compassion fatigue in relation to hospice social workers is a topic that remains underaddressed (Pelon, 2017). Quinn-Lee et al. (2014) offered that a qualitative inquiry can yield meaningful insight on hospice social workers' lived experiences in regard to burnout and anxiety related to death. Additional research that will provide a deeper and richer understanding of social workers' thoughts and feelings about their work with the dying is warranted (Pelon, 2017). Sansó et al. (2015) posited that the relationship between the ability to cope with death and hospice workers' quality of life continues to be an "important but under-addressed topic in the literature" (p. 205). Understanding how hospice social workers cope with death and dying on a daily basis, how they view compassion fatigue, and how their quality of life is affected will provide further knowledge that might be beneficial to not only social workers but perhaps to other professions as well.

## Problem Statement

Hospice social workers can experience satisfaction and growth in their work; however, constantly facing death places them at risk for compassion fatigue that could evolve into a desire to no longer continue working in the hospice field. Pelon (2017) set forth that compassion fatigue has been associated with changes in work productivity and diminished quality of care that the worker views as a "reflection of personal incompetence" (p. 136) and that may influence their decision to leave their profession. Compassion fatigue has been described as the "emotional cost of caring" and has led

professionals to abandon their work with traumatized victims (Slocum-Gori et al., 2011). Figley (2002) also concurred that as research advances, more evidence will be collected that compassion fatigue is a threat to the helping professional. If unattended, there will be losses not only to the profession but to clients who will also be affected. Also, the clinician's quality of life could be affected (Klein et al., 2018). Killian (2008) also noted the importance of further investigation to better position the helping professional to assist their clients.

In conducting this research, I engaged with the topics of compassion fatigue, quality of life, coping with death, hospice social work as a profession, and ethical mandates. Specifically, I attempted to address the need for qualitative research on hospice social workers' thoughts and feelings about their work with death and the dying. The study provides a deeper and richer understanding of the compassion fatigue phenomenon and how hospice social workers make meaning of their field experiences. In addition to furthering knowledge on the topic of compassion fatigue as it relates to hospice social workers, the study addressed the relationship between workers' ability to cope with their experiences and their quality of life.

## Purpose

The purpose of this descriptive qualitative inquiry was to obtain a deeper understanding of hospice social workers' experiences related to coping with death, the effects on their quality of life, and their experiences with compassion fatigue while working with death and dying daily in North Florida.

**Research Questions**

The RQs for this study were

RQ1: What are the experiences of hospice social workers related to coping with death and dying?

RQ2: How do their experiences affect their quality of life and their experiences with compassion fatigue?

**Conceptual Framework**

The conceptual framework for the study was the transactional theory of stress and coping, which defines coping as a person's effort to respond effectively to the challenges of a stressor and manage external or internal demands (Folkman, 1984; Folkman et al., 1986). In this theory, stress is viewed as a transaction between the individual and the environment. Craig and Sprang (2010) stated that there can be an optimum stress level; however, when the stress becomes excessive, it will challenge the effectiveness of the professional. Because of the nature of the mental health professional's work, there is a potential that stress could become excessive, placing the professional at risk for compassion fatigue. Folkman (1984) noted that in previous experiments, events that could be seen as controllable did not necessarily provide an indication of stress reduction.

The transactional theory of stress and coping proposes that coping has two primary functions: emotion-focused coping, which determines the regulation of a stressful situation, and problem-focused coping, which regulates the stressful emotions by modifying the environment that is causing the distress (Folkman et al., 1986; Lazarus, 1993). Compassion fatigue, being an empathic response to the suffering of clients, has a

correlation with how the mental health professional attempts to cope with the demands of their job. In this study, I used a qualitative approach from the transactional theory of stress and coping perspective to assist in understanding how the experiences that hospice social workers encounter while working with end of life influence their coping, quality of life, and risk for compassion fatigue.

## Nature of the Study

I used a generic qualitative inquiry (Kahlke, 2014; Percy et al., 2015; Thorne, 2016) to understand how hospice social workers in North Florida cope with death and dying, how working with death and dying affects their quality of life, what coping mechanisms they use, and what their experiences are related to compassion fatigue. It involved one-on-one phone interviews of hospice social workers who have been working in that capacity in direct services for at least 5 years. The interviews involved open-ended questions to elicit the view of the participants (see Creswell, 2014). I collected the data from hospice social workers via telephonic audio-recorded interviews. I manually coded interview data using Microsoft Excel spreadsheets. The Excel software allowed me to manage and organize the data, which allowed me to start seeing themes and patterns as they were emerging from the data collected. That information allowed me to construct an analytic framework and communicate the essence of what the data revealed (Patton, 2015). Given the small sample size and amount of data that were collected, manual coding was a viable option for this study. The analysis of the data included identifying common themes and patterns in the data in relation to the study's RQs, which assisted me in making sense of the data. The goal of the analysis of the data was to focus on what the

participant said and the context in which they shared their particular experiences (see Ravitch & Carl, 2016).

## Definitions

The following terms and definitions are used in this study:

*Burnout*: Stress that a professional encounters due to their work environment (Mota Vargas et al., 2016).

*Compassion fatigue*: A term (interchangeably called secondary traumatic stress and vicarious trauma) that denotes a psychological response to the stress of working with a high-stress population (Ledoux, 2015; West, 2015). Bride and Figley (2007) described compassion fatigue as an "unwanted effect while working with people who are suffering" (p. 152).

*Coping*: The individual's effort to manage a specific demand; it is the person's dynamic cognitive and behavioral effort to manage psychological stress (Lazarus, 1993).

*Countertransference*: Social workers' engagement on redirecting feelings to the client. Baker (2003) defined countertransference as an emotional reaction that could be conscious or unconscious and be feelings that emerge from the professional's own conflict that are projected onto the client.

*Empathy*: "The act of perceiving, understanding, experiencing, and responding to the emotional state or ideas of another person" (Baker, 2003, p. 141).

*Resiliency*: The ability to cope with continued stress resulting in future improvement as a professional (Mota Vargas et al., 2016).

*Quality of life*: An individual''s perception of their overall physical, psychological, and social satisfaction with their life (Post, 2014).

*Traumatic memories*: Experiences that could be a source of anxiety or distress (Ludick & Figley, 2016).

## Assumptions

I assumed in this study that hospice social workers who have been working for at least 5 years in hospice might be able to provide richer data due to their personal experiences having worked in the field for an extended period of time. Another assumption was that hospice social workers would be willing to participate in research to educate others on their work-related stress and how they manage those emotions and how they cope with working with the dying. There might be a misconception in my assumptions regarding the length of service and the knowledge acquired during that time. However, I will not know this without include workers who have been working with the dying for less than 5 years. As I discuss in Chapter 3, I was able to recruit a small sample via purposive sampling and did not encounter difficulty in acquiring willing participants for the study.

## Scope and Delimitations

In this study, I focused on compassion fatigue, coping with death, and quality of life among hospice social workers. Compassion fatigue has been explored in different levels, but most of the research has been quantitative (e.g., Alcide, et al., 2015; Pelon, 2017; Stensland, et al., 2017). I determined that a qualitative approach would better explain participants' emotions, feelings, and experiences as they would be able to process

and provide meaning to their experiences. Using this approach assisted in providing further insight about the phenomenon.

The participants were hospice social workers in North Florida who have been working with hospice in direct care for at least 5 years. There are four hospices in the Northeast area, two hospices in Tallahassee, and three in Pensacola; I invited all nine hospices' social workers to participate in the research. The social workers who met the eligibility criteria were be contacted for the interviews. Other hospice social workers such as supervisors or directors were not included if their work in a direct capacity with patients and their families for at least 5 consecutive years ceased more than 6 months from the time of the interviews.

In Chapter 3, I describe the research context step-by-step to provide insight on potential transferability and the assumptions that were made (see Creswell, 2014). However, because the focus of this study was specific to hospice social workers in a specific geographical area, the transferability of the data will be limited. Geographical area and time of services might affect the study's transferability as those factors might have influenced participants' lived experiences.

## Limitations

There are several limitations to this study. One limitation is that it only addressed the particularities of a specific professional group (social workers); other professional groups such as chaplains, nurses, doctors, bereavement counselors, and nurse practitioners were excluded. Another limitation was that hospice social workers who have

less than 5 years of direct care experience were not included. The geographical area is another limitation as this study only included the North Florida area.

The method was the generic qualitative design, a design in which boundaries are less defined (Kahlke, 2014). To improve the validity of the study, I used hand, or manual, coding. Hand coding provides a way to become more familiar with the emerging themes (Patton, 2015). A problem posed with manual coding was that it was very time-consuming as I also completed the verbatim transcription of every interview; however, making sure that transcripts were accurate also accounted for reliability in the study. Having a rich description of the data enabled me to convey the findings; as Creswell (2014) noted, a detailed description can add to the validity of the findings and provide an opportunity for self-reflection (Creswell, 2014).

One of the biases I had is that I have been a hospice social worker for almost 15 years, and I have my own understanding about compassion fatigue and how one copes with the death of clients. I also have an understanding about how the work has affected my own quality of life. I had to be very aware of not imposing my feelings when interpreting the data. To do so, I self-reflected and documented on a journal my feelings about the findings and how the interpretation of the findings might have impacted my perspective.

## Significance

Social workers are part of hospice caregiving efforts; however, they have a unique set of skills working with the terminally ill. For this reason, their coping strategies and needs can differ from those in other professions. It is essential that these helping

professionals also receive the support they need to compartmentalize and process their emotions to reduce caregiver fatigue and avoid burnout. Completing the interviews may have helped participants to make sense of their lived experience through recognition of similar experiences and the emotions resulting from the interviews (Quinn-Lee et al., 2014). In this study, I attempted to provide a deeper and richer understanding about social workers' ability to cope with death, the effect on their quality of life, and their experiences with compassion fatigue. Sardiwalla et al. (2007) noted that awareness and education is important as this will provide a perspective about the work performed by other hospice professionals.

This generic/basic qualitative inquiry provides insight as to what are the specific needs of hospice social workers. It also furthers understanding about their experiences about compassion fatigue, the need for support, and how their quality of life is affected by their daily experiences working with hospice patients and their families. Reflecting on their experiences could be helpful for other professionals. The study provides evidence-based recommendations of the level and type of support hospice social workers need to effectively and efficiently approach the daily demands of their work. Study findings also provide a richer understanding on how hospice social workers' ability to cope impacts their quality of life. The study results can inform the development of college-level educational programs and support for social workers who are interested in working with terminally ill patients.

Understanding the unique needs that hospice social workers have and learning from their perspectives may enhance social work practice by providing solutions to

similar experiences and problems. It is important that we understand the needs of social work practitioners working with the terminally ill as they do a pivotal job in society. If researchers and educators are able to understand their needs, they may be able to provide them with necessary resources so that they can continue the job they are doing in communities. Without this understanding and support, social workers as other health care professionals may be more likely to leave the profession because of secondary trauma (Sorenson, et al., 2016). Whitebird, et al., 2013 posed that is not new for hospices to have challenges retaining staff and obtaining new professionals to work in that field. Furthermore, hospice work is relatated with a higher risk of burnout that influence the decision of leaving or taking a prolong time from working with the terminally ill (Keidel, et al., 2002).

## Summary

Hospice social workers are uniquely positioned to provide counseling and support to the terminally ill and their families; however, the job demands can potentially put them at risk for compassion fatigue, a phenomenon reviewed in this research. Understanding their experiences, how they cope with death and dying daily, and the effects on their quality of life could position supervisors and organizations to provide support if necessary to assist these professionals. In the next chapter, I provide an in-depth analysis of the research supporting the study and the theory of stress and coping, which served as the conceptual framework. The literature review includes discussion of hospice social work, compassion fatigue, the implications of compassion fatigue for social workers.

Chapter 2: Literature Review

**Introduction**

In this literature review, I substantiate the need for further research on coping with death, quality of life, and compassion fatigue among hospice social workers. Sansó et al. (2015) noted the limited research on the relationship between the ability to cope with death and hospice workers' quality of life and suggested that this topic should continue to be addressed. Hospice social workers not only face the death of their clients, but the line of work could also provoke existential queries about their own emotions that could challenge their coping strategies. For these reasons, Whitebird et al. (2013) suggested that good social support and self-care are critical elements for coping and stress management. Adams et al. (2008) also identifed that people with social support and coping mechanisms are less inclined to be affected by stressors.

Although there are decades of research on compassion fatigue and there is a significant amount of quantitative research on compassion fatigue, burnout, and compassion satisfaction (e.g., Caringi, et al., 2017; Harr, 2011; Pelon, 2017; Sansó, et al., 2015, Stensland, et al., 2017; Whitebird, et. al., 2013), literature with an exclusive qualitative focus on hospice social workers coping with death, compassion fatigue, and their quality of life is limited. Researchers (e.g., Duarte, 2016; Harr, 2011; Strom-Gottfried, et al. 2006; Sorenson, et. al., 2016; Sansó, et. al., 2015; West, 2015) continue to reference older research done in the late 1990s and early 2000s as a foundation of their research. Furthermore, compassion fatigue in relation to hospice social workers is a topic that continues to be underaddressed (Pelon, 2017). For social work professionals in

general, secondary traumatic stress continues to be a risk, and further research is needed to provide an understanding of the implications of the phenomenon (Caringi et al., 2017). In particular, more research is needed to evaluate the degree to which compassion fatigue affects the personal and professional quality of life of health care providers working in various settings (Sorenson et al., 2016). Identifying factors that help professionals cope with the frequent exposure to death could enhance the quality of life of hospice social workers (Sansó et al., 2015). Additional inquiry is needed to understand social workers' thoughts and feelings about their work with the dying to understand their ability to cope with death and their own quality of life (Pelon, 2017; Sansó et al., 2015). I used a qualitative approach to address the gap in the literature. Quinn-Lee et al. (2014) noted that qualitative inquiry enables individuals to talk about their lived experience of burnout and death anxiety in ways that provides interpretation (p. 235).

The problem I addressed in this study is that compassion fatigue is a phenomenon that appears to be gaining increased attention in the helping profession, as it appears to be increasing in its prevalence, particularly among those who are providing care for chronic or acutely ill (Klein et al., 2018), the suffering, and the traumatized (Slocum-Gori et al., 2011). Hospice social workers are at a higher risk for developing compassion fatigue because of their service to patients and families during stressful and difficult times of their life while listening repeatedly to traumatic and upsetting situations (Alkema et al., 2008). These traumatic or upsetting experiences might be experiences from the past that were unresolved and emerge after a life-limiting diagnosis, prompting the patient to want to talk about the meaning of their life and try to make plans for the future while

struggling with the reality of a short time to live (Berzoff, 2008). The patient might

provide details about past traumas to resolve or make meaning of those past experiences.

Hospice social workers' exposure to death daily, dying patients, and grieving families is

often psychologically stressful (Pelon, 2017). Berzoff (2007) concurred that those who

work with the terminally ill may be vicariously traumatized. Klein et al. (2018) noted that

the recurrent exposure to patients who are suffering or dying can lead to not only

compassion fatigue but a diminished quality of life of the clinicians, which can result in

decreased concentration and productivity and a higher turnover of staff. Compassion

fatigue can have a negative impact on the workforce (Harr, 2013). Hospice social

workers who are continually facing death place themselves at a higher risk for

compassion fatigue that could evolve into the desire to no longer continue in the hospice

line of work.

Pelon (2017) stated that compassion fatigue has been associated with changes in

work productivity and a decline in quality of care that the worker views as a "reflection

of personal incompetence" (p. 136), which may result in their decision to leave their

profession. Figley (2002) concurred that as research advances, more evidence will

emerge that compassion fatigue is a threat to the helping professional. If unattended,

there will be losses not only on the profession but clients will also be affected. Also, the

clinician's quality of life component could be affected (Klein et al., 2018). Killian (2008)

emphasized the importance of further investigation to better position the helping

professional to assist their clients. Compassion fatigue has been described as the

"emotional cost of caring" (p. 173) and has led professionals to abandon their work with

traumatized victims (Slocum-Gori et al., 2011). When a patient dies, the hospice social worker experiences the loss of a relationship that was developed during a length of time, not only with the patient but with the caregiver.

Compassion fatigue is found to be an individual empathic response to the suffering of patients and their traumas (Alkema et al., 2008). Joinson (1992) described compassion fatigue as an exclusive form of burnout directly related to the caregiving professions (Hoffman et al., 2007). Bride and Figley (2007) described compassion fatigue as an "unwanted effect while working with people who are suffering" (p. 152). According to Strom-Gottfried and Mowbray (2006), compassion fatigue is the emotional distress that helping professionals feel from overexposure to their clients' traumatic events. Compassion fatigue is also related to professionals that work with trauma (Hoffman et al., 2007). Expers have argued that compassion fatigue is a direct result of the empathy and emotional investment of the helping professional (Strom-Gottfried & Mowbray, 2006); the professional can still carry on their work, but the quality of the work may be compromised (Slocum-Gori et al., 2011). Multiple studies have shown that compassion fatigue has debilitating effects in the lives of the helping professionals who work with the traumatized (Figley, 2002). It is understood that negative emotions that come while working with others can lead to compassion fatigue and burnout that could negatively affect the professional quality of life (Chan et al., 2015; Duarte et al., 2016). According to Hill et al. (2016), few researchers have addressed the well-being of the palliative worker even though their well-being ultimately will affect the quality of patient care. Caringi et al. (2017) suggested a need for more research related to secondary traumatic stress not

only as it relates to social workers but also to other related professionals. Pelon (2017) concurred that research about compassion fatigue in relation to hospice social workers remains somewhat under-studied.

Sardiwalla et al. (2007) posited that helping professions have always been associated with high levels of stress. O'Mahony et al. (2018) added that palliative care professionals are at risk for higher levels of stress. The hospice worker is vulnerable to compassion fatigue because of their constant exposure to the loss of the clients and their awareness of their mortality (Keidel, 2002). The literature review has shown that compassion fatigue can present in different forms. Although not all might experience compassion fatigue, it is still a possibility due to the nature of the caring profession. Some of the emotions identified with compassion fatigue and the professionals providing care are feelings of regret, anger, and hopelessness (Strom-Gottfried & Mowbray, 2006).

In this chapter, I review the literature on compassion fatigue, coping with death, and quality of life in hospice social work. In addition, hospice social work as a profession and ethical mandates are discussed. Joinson (1992) initially recognized the phenomenon of compassion fatigue in the nursing profession; since its identification, compassion fatigue has been extensively examined in peer-reviewed nursing journals. Researchers have also examined the phenomenon in other professions such as chaplains, licensed mental health counselors, and volunteers; however, limited research has been done mainly with hospice social workers, according to my review of the litearture. Before reviewing the literature, I describe the literature search strategy and provide an overview of the conceptual framework.

**Literature Search Strategy**

The literature review includes literature from 2013 to 2019 inclusive. I also include seminal work in the area of compassion fatigue from the 1990s because most of the recent literature (e.g., Caringi, et al, 2017; Sinclair, et al., 2017; Ludick, et al., 2017) continues to refer older research (e.g., Figley, 1995). Seminal literature pertaining to the theoretical framework from the 1980s is also included. Articles focusing on the major themes were selected for review.

I conducted digital searches of the literature using databases that included Google Scholar, PsychINFO, SocINDEX with Full Text, Social Work Abstracts, Academic Search Complete, ERIC, EBSCO, MEDLINE, ProQuest Central, PubMed, and Science Direct. I also used Thoreau Multi-Database Search. All the articles used as a source were obtained digitally. Search terms included *compassion fatigue*, *coping with death*, *coping*, *stress*, *hospice*, *quality of life*, *hospice social workers*, and *social workers*. The search resulted in 463 articles met inclusion criteria, I utilized 59 sources. The search was stopped when saturation was met.

**Conceptual Framework**

The conceptual framework for the study was the transactional theory of stress and coping that defines coping as a person's effort to respond effectively to the challenges of a stressor and manage external or internal demands (Folkman, 1984; Folkman et al., 1986). The transactional theory of stress and coping suggests that the interaction between the primary and secondary appraisal determines an individual's stress response and quality of life; the relationship between the person and the environment will have an

impact on their stress reaction and their quality of life (Prati et al., 2010). Stress is viewed as a transaction between the individual and the environment. Craig and Sprang (2010) observed that there can be an optimum stress level; however, when the stress becomes excessive, it will challenge the effectiveness of the professional. Because of the nature of mental health professionals' work, there is a potential that stress could become excessive, placing the professional at risk for compassion fatigue, which could eventually develop into burnout. Folkman (1984) stated that in previous experiments, events that could be seen as controllable did not necessarily provide an indication of stress reduction.

The transactional theory of stress and coping posits that there are two processes, cognitive appraisal and coping, that mediate stressful situations. Cognitive appraisal involves an individual evaluating the significance of what is happening to them and their well-being (Folkman et al., 1986; Ntoumanis et al., 2009). The appraisal stage is divided into two stages: primary and secondary. In the primary stage, the person evaluates how the encounter is going to affect them; the person's values, assumptive world, perceptual lens, general beliefs, and preconceived notions are significant to primary appraisal as those beliefs are what will shape how the encounter will be considered. During their interaction with patients and their families, hospice social workers will encounter situations where their personal values, assumptive world, and general beliefs will be challenged. According to the primary appraisal stage, there is an evaluation of how that encounter will affect them. In the secondary stage, there is an evaluation of coping resources. In this stage, the evaluation will be whether there is anything that can be done to prevent the impact, coping options, and problem-solving (Folkman, 1984). In to the

secondary stage, hospice social workers will problem-solve if there is something that can be done during that encounter to prevent an impact on their well-being. The primary and secondary appraisal will work simultaneously to evaluate a situation and determine if the situation is perceived as stressful. The significance that the person will provide to the event is what will determine the coping mechanisms; the significance could range from harmful, loss, threat, challenge, or nonthreatening (Folkman & Moskowitz, 2004; Ntoumanis et al., 2009). According to Folkman and Moskowitz (2004), the negative appraisals are accompanied by negative feelings; however, challenges are seen as possibilities to overcome, although it could bring failure. In that case, the emotions could be positive or negative. Job satisfaction may emerge from a positive impact whereas burnout could result from a negative impact.

Coping is the individual's effort to manage a specific demand; it is the person's dynamic, cognitive and behavioral effort to manage psychological stress (Lazarus, 1993). According to the theory, coping can be classified as adaptive or nonadaptive. The adaptive component is a positive component that improves the outcome by achieving a way of coping. This approach poses that coping has two essential functions: emotion-focused, which determines the regulation of a stressful situation by changing the relationship between the person and environment (changing the meaning of what is happening), and problem-focused coping, which regulates the stressful emotions by modifying the environment that is causing the distress in an attempt to resolve the stressful encounter (Folkman, 1984; Folkman et al., 1986; Lazarus, 1993; Ntoumanis et al., 2009). Coping is not a universal response to a situation, but an individual response to

a situation as coping strategies that are effective to one person might not be effective for another (Lazarus, 1993). The stress process and coping model could not only provide an understanding of how appraisal of the event will determine coping responses and how the coping response affects the quality of life of an individual.

## Literature Review Related to Key Variables and/or Concepts

### Burnout and Secondary Trauma

Social workers work with a variety of clients. Some of those clients might have been affected by a trauma. Although social workers have the training, according to Caringi et al. (2017), they are not exempt from being vicariously affected by those experiences. For that reason, secondary trauma has been identified as an occupational hazard for the helping professions. Diaconescu (2015) suggested that burnout is a well-recognized chronic social problem. However, it posed that because secondary traumatic stress is less known or maybe minimalized in social work, it lacks the necessary resources for prevention and education. Diaconescu (2015) suggested that the helping professionals should be self-aware of their abilities, attitudes, exposure to suffering, and organizational environment. This will assist the social worker in the limitation or prevention of burnout. It is also suggested that supervision might be a system that could assist the worker in coping with the work stress. One study by Alkema et al. (2008) found that burnout was a response to occupational stress, while compassion fatigue was more of an individual response related to the exposure of the client's experiences with suffering and trauma. Keidel (2006) concurred with the belief that there is a difference between compassion fatigue and burnout.

I proposed that burnout is a physical exhaustion that includes a negative self-concept and loss of concerns or feelings for patients. Burnout presents differently than compassion fatigue as it is a response to a prolonged exposure that will place the worker on emotional exhaustion because of high involvement; inadequate support or lack of satisfaction may place the professional in a vulnerable position to develop burnout (Adams et al., 2008). Research suggests that some of the possible contributing factors for compassion fatigue in social workers could be poor self-care, the inability to manage work stressors, and the lack of job satisfaction (Harr, 2011). Sinclair et al. (2017) refer to burnout as the lack of interest in work and is associated with many occupations makes the distinction that compassion fatigue has an acute onset of physical and emotional responses, concurring with Figley (1995), who also defined compassion fatigue as sudden.

**Compassion Fatigue, Vicarious Trauma, and Social Workers**

Through the literature, the term "compassion fatigue" has been interchangeably called secondary traumatic stress, vicarious trauma to note a psychological response to the stress of working with a high-stress population (Ledoux, 2015; West, 2015). Compassion fatigue has been considered an occupational stress response in healthcare providers (Mathieu, 2012) and palliative care workers (Chan et al., 2015), an occupational hazard that appears to be increasing among the health care workers (Harr & Moore, 2011; Klein et al., 2018). Figley (1995) developed the concept of compassion fatigue as what some describe as a "friendlier term" emerging from the observations of what seemed to be a strong empathic response to the work with traumatized clients, also

known as a secondary trauma or vicarious trauma (Adams et al., 2008; Diaconescu, 2015; Harr, 2013; Sorenson et al., 2016) and often has been described as "the emotional cost of caring" (Diaconescu, 2015; Figley, 1995; Slocum-Gori et al., 2011). It refers to the adverse psychological stress associated with helping or wanting to help a traumatized or suffering person (Figley, 2002; West, 2015). Compassion fatigue is found to be an individual empathic response to the suffering of patients and their traumas (Alkema et al., 2008; Figley, 1995). Mota Vargas et al. (2016) refer to compassion fatigue as an emotional state that contributes to physical and psychological negative consequences for the caring professional that absorbs the client's distress.

Joinson (1992) described compassion fatigue as a unique form of burnout directly related to the caregiving/ helping professions (Hoffman et al., 2007). Bride and Figley (2007) described compassion fatigue as an "unwanted effect while working with people who are suffering" (p. 152). It is believed that compassion fatigue is a direct result of the empathy and emotional investment of the helping professional (Strom-Gottfried & Mowbray, 2006); the professional can still carry on their work, but the quality of the work may be compromised (Slocum-Gori et al., 2011). Figley (1995) suggested that compassion fatigue is difficult to anticipate. Diaconescu (2015) poses that the worker experiencing compassion fatigue, quality of professional and personal life might be affected.  Some of the symptoms of compassion fatigue emerging from the literature are anxiety, guilt, fear, sadness, difficulty in concentrating, questioning their professional capabilities, reduced ability to feel empathy, disruption to personal worldview, and intrusive imaginary (Figley, 1995; Mathieu, 2012; Diaconescu, 2015), which according to

literature, this secondary traumatic stress has similarities with post-traumatic stress disorder Diaconescu, 2015; Harr, 2013). There has been a distinction made between compassion fatigue, secondary traumatic stress disorder, vicarious trauma, and burnout. Compassion fatigue is suggested to be the precursor for burnout and a form of secondary traumatic stress absorbed by the professional from listening to their clients' experiences (Wagman et al., 2015). In research conducted by Ludick in 2013 with claims workers, it was found that absenteeism was related to having to take sick leave to be able to cope with their secondary traumatic stress, with some workers having been found to have some degrees of post-traumatic stress disorder as a result of their secondary trauma (Ludick & Figley, 2016).

Compassion fatigue differs from burnout as burnout is a consequence of compassion fatigue not resolved. Burnout has been referred to as the overwhelming feeling of emotional exhaustion, including depersonalization and professional inadequacy as a gradual process (Wagman et al., 2015), unlike compassion fatigue which is a sudden experience (Figley, 1995). Ludick and Figley (2016) identify that exposure to suffering is the first pathway to secondary traumatic stress, especially if the counselor has a higher trauma caseload. It is essential to recognize that compassion fatigue is a reality of the professionals' line of work and not necessarily a weakness of the practitioner (Harr, 2013). Compassion fatigue may be treatable (Adams et al., 2006; Figley, 2002). Adams et al. (2008) utilized the stress process and coping framework to study compassion fatigue among social workers living in New York City following September 11, 2001, terrorist

attacks on the World Trade Center. Harr (2013) posits that a stress process framework assists in explaining compassion fatigue.

**Empathy and Social Workers**

Empathy, according to the social work dictionary (Baker, 2003), is "the act of perceiving, understanding, experiencing and responding to the emotional state or ideas of another person" (p. 141). Since compassion fatigue has been related to an emphatic response, as per Figley (2002), there is an assumption that empathy is a pathway for compassion fatigue as the ability to connect with the client and notice their suffering is the core of the helping professions. Also, Ludick and  Figley (2016) reiterated that the main channel for secondary traumatic stress is the empathic concern of the helping professions; the more the professional is engaging emotionally, the greater the probabilities for personal distress. If the emotional connection does not occur, then it is assumed that there is no compassion fatigue outcome.

Ludick and Figley (2016) pose that exposure to a client's suffering during multiple encounters and the more the professional connects with the client's pain increases the likelihood of compassion fatigue. However, once again the empathic response and communication are essential when working with end of life as the social worker will connect with the pain, suffering, feeling, and the death of the client, and it is considered a complex process involving both physical and cognitive processes (Galiana et al., 2019; Ludick & Figley, 2016; Thomas, 2013). Wagman et al. (2015) suggest that empathy is a combination of cognitive and physiological processes. Their findings are contrary to the belief that could make the helping professional vulnerable to compassion

fatigue, suggesting that empathy may prevent or reduce burnout and secondary traumatic stress while increasing compassion satisfaction. Duarte et al. (2016) concur with Wagman et al. (2015) that if empathic concerns are made with consciousness, awareness, and understanding, that those feelings and not their own feelings will turn to a satisfactory feeling about caring for others.

**Traumatic Memories and Social Workers**

Ludick and Figley (2016) suggest that the person's history of traumatic experiences might contribute to the response of secondary traumatic stress as they posed that it could be a source of further distress and anxiety; Ludick (2013) research found that trauma counselors reported that their own traumas affected their ability to assist clients. Harr (2013) posed that social workers with a previous history of trauma could be at a higher risk for compassion fatigue. Traumatic memories could be not only the person's own trauma experiences, but they could also be identifying the traumatic memories accumulated during the time providing counseling (Figley, 2002); In Ludick and Figley's research (2016), they posed that trauma counselors made mention that their personal traumas impacted their ability to assist clients, which introduced more distress to the worker. They mention that McCann and Pearlman's research in 1990 refers to the workers' recollection of their own traumatic experiences while working can return mimicking post-traumatic stress disorder symptoms.

**Hospice Social Work**

Social workers who practice in hospice and palliative care must be prepared for challenges that include ethical dilemmas and value conflicts (National Association of

Social Workers [NASW], 2004). The need for trained hospice and palliative care social workers has increased as complexities in chronic illnesses, and medical advancements have increased. The hospice social worker will be working as part of an interdisciplinary team. The work with the dying will be consistent with working with systems to facilitate, advocate, and support patients and families at the end of life (Berzoff, 2008), decision making and the complex medical and social system while providing psychosocial support at the end of life (Alcide & Potocky, 2015), and facilitating difficult conversations between patients and physicians. The social worker will develop a relationship with the patient and family while providing empathy and culturally sensitive support. Although part of the social workers' role in hospice is to assess psychosocial needs such as coping, depression, anxiety, and suicidal ideations (Alcide & Potocky, 2015), it is also necessary to understand diagnosis, disease progression, and the dying process to educate the patient and the family with respect to adaptation to illness and environment. Hospice social workers will need to be able to assess how the patient and the family cope with the disease and how they adapt to their environment while working with an interdisciplinary team.

Hospice social workers empathize with the losses of their patients and families. As they work with this population, they are reminded daily of the fragility of life (Slocum-Gori et al., 2011), and they must manage their own emotions to help others manage theirs (Stensland & Landsman, 2017). Working with repeated exposure to death has numerous emotional demands, including challenging core beliefs, absorption of negative emotional responses, working in uncertainty, patient suffering, and stress (Hill et

al., 2016). It also exposes existential issues, emotional distress, and psychological challenges as the hospice social worker might be giving the news to a family member that there is no cure. According to Hill et al. (2016), in one study, an estimated 50% of palliative care staff is at risk for "poor psychological outcomes" (p. 826) because of their inability to cope with the job demands. Hospice social workers could not only be facing their patients' ends of life, but their perception of life and death can be a source of anxiety and expose existential issues as they could also be facing their mortality or facing the loss or decline of a loved one. Hospice workers experience satisfaction and growth in their work. However, facing death daily can create over time burnout if unattended.

**Implications of Compassion Fatigue and Burnout for Social Workers**

The code of ethics for a profession is what provides guidelines to the therapeutic relationship between the professional and the client (Avieli et al., 2015). Social workers are bound by the NASW Code of Ethics, which was revised in August of 2017 and delineated how social workers should conduct themselves, and what is expected of them as a professional, along with the responsibilities that social workers have with their clients, their profession, themselves and their colleagues (NASW 2017).

Countertransference is social workers' engagement in redirecting feelings to the client. Harr (2013) poses that social workers that do not maintain healthy boundaries or do not deal effectively with countertransference are susceptible to develop symptoms of compassion fatigue. On the other hand, Berzoff (2008) posed that professionals who work with the dying may experience some specific countertransference such as aversion, shame, anger, and sorrow, hoping that those feelings will go away and recommends that

debriefing might help the worker. Radey and Figley (2007) suggest that debriefing should be integrated as part of the job to assist the workers in coping with compassion fatigue.

Boundaries are maintained as an ethical behavior to contribute to the quality of life of the helping professional. Ethical practices and code of ethics of the profession maintain a differentiation in boundaries while maintaining an empathic engagement (Avieli et al., 2015). The research of Avieli et al. (2015) concluded that ethical behaviors and the preservation of boundaries might prevent or help with the minimization of secondary traumatic stress, the preservation of healthy levels of compassion fatigue, and a healthy professional quality of life amongst professionals who assist trauma victims. However, what will be considered healthy levels of compassion fatigue is somewhat subjective as this could be variable among people experiencing the symptoms. Another issue will be that professionals that might be experiencing signs of compassion fatigue might not be open to discuss their feelings as this could be perceived as a weakness, lack of competence, and diminished professionalism, which will then become an ethical issue as the clients' services could become compromised; this should be addressed by the profession and its supervisors and organizations (Harr, 2013). The NASW Code of Ethics mandates that if the social worker feels their work is compromised, they should seek consultation and follow the appropriate steps to ensure not only their well-being but also the client's; the mandate includes colleagues and employers once aware providing support and assists them with taking remedial actions (NASW, 2017).

***Self-Awareness***

It is suggested that self-awareness can act as a protective mechanism against compassion fatigue for palliative and health care providers (Sansó et al., 2015). The capacity to establish boundaries while maintaining empathy is essential to self-awareness. Self-awareness will assist the worker in recognizing and understanding their emotions and will assist with emotion regulation. Wagaman et al. (2015) refer to self-awareness as a cognitive component of empathy and the ability to maintain a separation of the worker's feelings from others and to set and maintain boundaries. Social workers are expected ethically to self-monitor for possible psychological distress (NASW, 2017).

**Summary**

In this chapter, I reviewed the literature on compassion fatigue, coping, quality of life, and hospice social workers. Many human and health professions have researched compassion fatigue. Emerging from research is some understanding of how this phenomenon affects health and mental health practitioners. It is understood that compassion fatigue has been considered an occupational hazard that could affect social workers working with patients at the end of their lives. In the research, it is shown that compassion fatigue is not a phenomenon that might affect all practitioners; however, in the hospice social work profession, it is a potential because of the nature of the work, which involves the stress of bearing the news of a terminal condition and assisting the patient in processing their emotions while possibly encountering other distressing emotions or traumas that may be accessed during the time of counseling. Other factors might contribute to compassion fatigue. The quality of life of the professional might be at

risk if the stressors become too overwhelming. Rather than the lack of professional boundaries, our traumas might make the professional vulnerable to compassion fatigue.

With this descriptive qualitative research, I explored coping with death, compassion, compassion fatigue, and quality of life among hospice social workers. The research attempted to provide an extended knowledge about how hospice social workers cope and their thoughts and feelings about their work with the dying and their families. It also attempted to understand how coping with death affects the hospice social worker's quality of life. This research could provide meaningful information to not only social workers but other professions.

Chapter 3: Research Method

**Introduction**

The purpose of this descriptive qualitative inquiry was to obtain a deeper understanding of hospice social workers' experiences related to coping with death, the effects on their quality of life, and their experiences with compassion fatigue while working with death and dying daily in North Florida (Tallahassee, Jacksonville, Pensacola). I begin this chapter by providing information about the research design and the rationale for its selection. Brief definitions of the main concepts in the study are included. This chapter also includes discussion of the role of the researcher and positionality; participants; sampling, and how the data were collected and analyzed. I also discuss issues of trustworthiness (i.e., credibility, transferability, dependability, confirmability), credibility/validity were established, and the ethical procedures used in the research.

**Research Design and Rationale**

The RQs for this study were

RQ1: What are the experiences of hospice social workers related to coping with death and dying?

RQ2: How do their experiences affect their quality of life and their experiences with compassion fatigue?

The central concepts of this study were compassion fatigue, coping with death, and quality of life among hospice social workers, who are an integral part of the interdisciplinary team and work with individuals who have been deemed to have months

to 1 year to live. Hospice social workers support patients and families with decision-making within the complex medical and social system while providing psychosocial support at the end of life, in addition to facilitating difficult conversations between patients and physicians (Alcide & Potocky, 2015; Berzoff, 2008). Hospice social workers work with individuals at the end of life in multiple settings that include hospitals, homes, nursing homes, assisted living facilities, senior centers, adult day care, child welfare, and corrections, amongst others, using a multidimensional approach (NASW, 2004). This approach includes advanced planning and work with a range of issues that will arise while facing the end of life. The following are key concepts that are used in the study:

*Compassion fatigue* has been interchangeably called *secondary traumatic stress* and *vicarious trauma* to denote a psychological response to the stress of working with a high-stress population (Ledoux, 2015; West, 2015). Bride and Figley (2007) described compassion fatigue as an "unwanted effect while working with people who are suffering" (p. 152).

*Burnout* refers to the professional's stress with their work environment (Mota Vargas et al. 2016).

*Coping* is the individual's effort to manage a specific demand; it is the person's dynamic cognitive and behavioral effort to manage psychological stress (Lazarus, 1993).

*Countertransference* is social workers' engagement in redirecting feelings to the client. Baker (2003) defined countertransference as an emotional reaction that could be conscious or unconscious and consist of feelings that emerge from the professional's own conflict that are projected onto the client.

*Empathy*, according to the social work dictionary (Baker, 2003), is "the act of perceiving, understanding, experiencing, and responding to the emotional state or ideas of another person" (p. 141).

*Quality of life* is an individual's perception of their overall physical, psychological, and social satisfaction with their life (Post, 2014).

*Resiliency* has been defined as the ability to cope with continued stress resulting in future improvement as a professional (Mota Vargas et al., 2016).

*Traumatic memories* are experiences that could be a source of anxiety or distress (Ludick & Figley, 2016).

**Method**

I determined that a generic qualitative design (Kahlke, 2014; Percy et al., 2016; Ravitch & Carl, 2016; Thorne, 2016) was best suited for the study as it allowed for the exploration of emergent themes regarding how hospice social workers cope with their lived experiences, how their work affects their quality of life, and how their experiences relate to compassion fatigue. I used the generic qualitative method to understand how the participants view and experience their world while making meaning of their experiences in the phenomena (see Patton, 2015; Ravitch & Carl, 2016); the individuals experiencing the phenomenon are the experts and their perspectives and experiences provide the context in how they view their lives and those experiences. The generic qualitative study provides a thematic description and patterns that can be used to generate descriptive knowledge (Thorne, 2016). Quantitative instruments or close-ended questions were not

appropriate because these would not provide deep understanding of the phenomenon. I explored the experiences of a specific professional group, hospice social workers.

## Role of the Researcher

In qualitative studies, the researcher acts as the primary instrument for the collection of data, doing so through observation, documentation, and interviewing (Creswell, 2014; Ravitch & Carl, 2016). During this qualitative research, my role included collecting and transforming the data into patterns, categories, and themes to make sense of the phenomenon studied. The process was inductive as I was building concepts that emerged from the participants' descriptions (Ravitch & Carl, 2016; Thorne, 2017). I collected the data during individual telephonic interviews. I asked open-ended questions to ascertain how the participant made meaning of their emotional reactions on the job, including their perception and experiences (Patton, 2015). The interviews were audio-recorded. I analyzed the data by building patterns, categories, and themes and focused on learning and understanding the answers and meaning that the participants gave in response to the questions posed. Participants were asked to reflect on their own experiences and their role in the study. The reflection on my own experiences and competence allowed me to see if I was being less than neutral during the data analysis and avoiding biases (Creswell, 2014). I collected the data from the participants who were directly involved with the phenomenon. It was imperative that I have some understanding of the phenomenon that was being studied.

**Positionality**

Because I have been working for a hospice in Northeast Florida for the last 15 years, I have personal beliefs of how working daily with death and dying, compassion fatigue, and quality of life have shaped my views of life. Although I work with hospice, I do not hold a supervisory position. There was the possibility that some participants might be coworkers but not necessarily people whom I work with on a daily basis as there are many teams in the company. Because of the possibility of having coworkers participate in the study, I had to be very clear that this was a research study and the information collected would be used strictly for research purposes as they might not want to be as open to discuss their feelings due to fear that the information might be shared with others, including management, at work. Also, I reached out to all hospices in the North Florida area to access participants from different organizations.

I needed to constantly reflect on my own experiences during the interviews and the analysis of the data. I used reflective journaling as a tool during my research (Ravitch & Carl, 2016). I wrote down my feelings as I was engaging in the process of interviewing and analyzing the data; this helped me to keep my feelings during the process in check to avoid biases as I was able to reflect on my own experiences, values, and assumptive worldview while analyzing and interpreting the data. The process of writing thoughts, ideas, and questions helped me understand my role as a researcher and my role in the data collection (Thorne, 2016). It assisted me in staying objective during the process as I reflected on my values and assumptions, which ensured the validity of the research as I was scrutinizing for biases, which also served to promote reflection on the research

process on a much deeper level. Because the participants were donating their valuable

time to participate in the research voluntarily, I gave them as a token of appreciation for

their participation, a $10.00 gift card to a coffee shop, at the end of the interview.

## Methodology

The data source in this study was individual interviews. The interviews provided

an in-depth understanding of the meaning the participants gave to the phenomenon of

compassion fatigue in hospice social work practice. The individual interviews were

semistructured with open-ended questions that provided the opportunity for participants

to talk about not only their experiences but their feelings and the meaning that those

experiences have in their lives as hospice social workers and how it impacts their quality

of life.

### Participant Selection Logic

In this study, I attempted to obtain the participation of hospice social workers in

the North Florida area who have been working with hospice in direct patient care during

the last 5 years. I used purposive sampling to select participants because it was necessary

that the participants have in-depth, rich knowledge, and experience regarding the

phenomenon that was the subject of this research study (see Creswell, 2014; Ravitch &

Carl, 2016; Thorne, 2016). The purposive sampling allowed me to deliberately select

individuals who have experiences that helped me get the information needed to answer

my two RQs. I deliberately selected hospice social workers because they had the

knowledge and experience to uniquely answer the interview questions. The size of the

sample in a qualitative study is usually small (Creswell, 2014). I interviewed eight

participants. This number of participants was sufficient to acquire the information needed to answer the RQs. By engaging with a small number of individuals with lived experiences related to the study topic and a willingness to share their perspectives, I believe that I was able to elicit rich information, which allows for transferability. The criteria to be a participant was that the participants had been working in hospice with terminally ill patients and their families in various settings, including home, inpatient, and long-term care facilities for the last 5 years. The assumption was that these participants had been doing the work for a longer period of time and have extensive experience in their field.

**Instrumentation**

Individual interviewing was the source of data collection. Semistructured, open-ended questions allowed the participants to share and provide meaning to their experiences. There was a total of 11 questions. I designed the interview questions to obtain knowledge on hospice social workers' experiences related to coping with death, the effects on their quality of life, and their experiences with compassion fatigue while working with death and dying daily (see Appendix).

**Procedures for Recruitment, Participation, and Data Collection**

I sent a letter of intent via e-mail to directors to hospices in North Florida requesting their cooperation in disseminating the intent for the study to their social workers. The letter explained the specific requirements to participate in the research and had my contact information to be provided to their employees as a method to contact me. Once the participants contacted me, they were asked two questions that determined their

eligibility: First, if they have been working with hospice direct patient care for at least 5 years, and second, if they hold a supervisory position. If they did not meet the criteria, they were thanked for their willingness to participate and were not interviewed. If they were eligible to continue with the study, arrangements were made for a date and time that was convenient for the participants. The interview was by phone and recorded.

The participants received information about informed consent and were asked to sign an informed consent to authorize their participation in the study and the audio-recording of their interviews. I also collected demographic information at the beginning of the interview.

The data was collected via audiotape during phone interviews because of the COVID-19 pandemic. The interviews were between 45 minutes to 1-hour. The interviews were done at their convenience, including weekends. The phone interviews allowed me to interview hospice social workers that were not in my immediate area. I sent another invitation to the hospices 2 weeks later as a reminder. Participants that had contacted me but did not give me a date and time were approached for a second time as a reminder. I asked the participants if they were willing to participate in reading the findings. If they were willing to do so, I sent them a copy of the themes collected during their interview to determine accuracy (i.e., member checking).

**Data Analysis Plan**

The data analysis was done by manual coding. I utilized Microsoft Word and Excel spreadsheets, utilizing hand-coding allowed me as a researcher to become more familiar with the emerging themes. I stayed true to the information collected by

transcribing the data verbatim soon after the interviews were done. Because I was the one transcribing the data, this also allowed for further protection of the data. The content analysis included coding to summarize or condense the data (Saldaña, 2016), identifying common themes and patterns in the data in relation to the study's RQs. Content analysis seemed to be the most appropriate way to analyze the data since this was my first qualitative study. I am learning to code the data; this method allowed the preservation of the participants' meaning of their views (Saldaña, 2016).

## Issues of Trustworthiness

### Credibility

To improve the credibility or validity of the study, I utilized manual coding to ensure the coding was accurate. Also, I used a thick, rich description of the data to affirm that my data findings are faithful to the participants' experiences (Creswell, 2014; Ravitch & Carl, 2016). This method, along with member checking (Creswell, 2014) with the participants who were willing to do so, provided validation and helped ensure the study's credibility. If there were willing participants, I utilized member checking to determine the accuracy of the findings; I sent them a copy of the themes collected during their interview for their acceptance or revision in order to determine the accuracy of the findings (Creswell, 2014). Three participants out of the eight that were interviewed agreed and participated in member checking. Also, to ensure the accuracy of the information collected during the interview, I verified the information with the participant as they answered questions to ensure that I understood what they meant (Shenton, 2004).

**Transferability**

To achieve transferability, the study should include a thick description so the readers could have as much information as possible. I needed to do a thorough job of describing the research context step by step for potential transferability and the assumptions made (Creswell, 2014); double-checking that there are no mistakes during transcription allowed for reliability in the process. I transcribed every interview verbatim soon after each interview; this way, I stayed true to the collection of the information, and to support the study's transferability, I provided participants own words describing their experiences, this allows a detailed description of the context and the people that were interviewed (Connelly, 2016). The extension of the application of this study to other settings may not be as relatable as the particularities of this study are for a specific group of participants, and they might not apply to other populations or situations (Shenton, 2004).

**Dependability**

The research method I chose was qualitative. It would allow me to answer my RQs by providing deep rich information about how hospice social workers cope with death and dying and deal with compassion fatigue and their quality of life. This was the most appropriate method as it will allowed the hospice social workers to provide insight into the phenomenon while enabling them to give meaning to their experiences. There was a participant sample of eight that allowed for saturation. The interview questions provided dependability as they were targeted towards answering the RQs (Ravitch & Carl, 2016). The individual telephonic interviews allowed the participants to openly

discuss their experiences as hospice social workers while giving meaning to their experiences. The interview questions were targeted to answer the two RQs: (a) What are the experiences of hospice social workers related to coping with death and dying? and (b) How do their experiences affect their quality of life and their experiences with compassion fatigue? The study provides a procedure on how the study was conducted; this shows dependability as the details will enable the reader to assess the extent to how the research followed proper research practices and allows other researchers to repeat the work (Shenton, 2004).

**Confirmability**

Because of the prolonged time I have been in the field of study, it was vital for me to maintain a closer look at biases during the analysis. To do that, I kept a reflective journal of my experiences and feelings during the process. Reflective journaling was utilized as a tool during the research to assess emotions, concerns, and biases. To assist in maintaining objectivity during the analysis of the data (Erlingsson & Brysiewicz, 2017). As I wrote the journal, it allowed me to explore and acknowledge any biases in my interpretations (Ravitch & Carl, 2016). In my journal, I reflected on my own experiences during the interviews and the data analysis. I reflected on my experiences as a hospice social worker, values, and my assumptive world. This tool helped me keep my feelings apart from the research and be objective, promoting self-reflection on my personal beliefs and not allowing them to affect my analysis process. At the time, offering a way to understand the participants on a deeper level and help me understand and keep in check that I was a researcher collecting data from others' experiences in this particular situation.

**Ethical Procedures**

The purpose of Walden University's Institutional Review Board's (IRB) approval is to maintain ethical principles in research and present minimal or no risk during the research to the participants and the researcher. An application for IRB approval was initiated and submitted to allow the researcher to collect data. The Walden University IRB approved the collection of the data in June of 2020 (06-10-20-0570400). After the application was approved, I started the process of making contact with the agencies to start the research study. The participants were hospice social workers talking about their experiences; the topic was not considered a sensitive topic; however, because social workers were sharing their experiences, there was a possibility that they would have negative feelings or discomfort that could arise during the interview. A list of counseling services in the area was offered if they felt the need for counseling afterward. The participants were not considered a vulnerable population, and there was no known harm interconnected with this study.

Data was collected via audiotape without identifiable information or contact information of the participant. The demographics were kept in a locked filing cabinet. The interviews and data were kept on a secure electronic file in a computer accessed by touch technology. Data was only accessible by me and committee members if needed. An ethical issue that was reviewed is the possibility of having participants from the company that I work with; there was a strong delineation that the information obtained is for research purposes that have nothing to do with work. Two social workers work on my team, and they were not considered to participate in this research. I do not hold a

supervisory position, so this was not an ethical concern. I presented each participant with a gift card ($10.00) in appreciation for their time to participate in the research. The coffee shop gift card was issued as a token of appreciation for taking time to participate and not as an incentive to participate in the study.

## Summary

In this chapter, I delineated the research design and rationale, the role of the researcher, and the researcher positionality. Methodology, identification of participants, the sampling method, and the procedure have been discussed in this chapter. Also, data collection, treatment, and analysis of the data, trustworthiness issues, including transferability, dependability, and confirmability, have been discussed, and ethical considerations are part of this chapter. In Chapter 4, I will review the data collection and analysis.

Chapter 4: Results

**Introduction**

The purpose of this descriptive qualitative inquiry was to obtain a deeper understanding of hospice social workers' experiences related to coping with death, the effects on their quality of life, and their experiences with compassion fatigue while working with death and dying daily in North Florida. The RQs were as follows:

RQ1: What are the experiences of hospice social workers related to coping with death and dying?

RQ2: How do their experiences affect their quality of life and their experiences with compassion fatigue?

In this chapter, I will describe the setting, demographics, data collection, and data analysis, in addition to presenting evidence of trustworthiness and the results of this research.

**Setting**

I conducted the study via phone calls only. My intention was to conduct face-to-face interviews; however, that was not feasible amid the COVID-19 pandemic. COVID-19 might have affected some aspects of the study as there was no face-to-face interaction and I was not able to observe the participants. The restrictions stemming from the COVID-19 pandemic might have affected how the participants felt about their jobs and imposed some additional stressors related to their daily activities. In relation to long-term care, participating social workers' facilities went into lockdown, not allowing them to do in-person visits but at times being able to do telehealth visits. Long-term care social

workers who were able to visit and support families were more needed as families were not allowed in the facilities and relied on hospice staff to provide support and information about patients' conditions, especially if the patient was declining. The family was not allowed in the facility to see their loved ones. Home social workers' visits might not be done in person depending on the level of the family's comfort, and the addition of personal protective equipment created a significant change in regard to their daily routines. During the interviews, some participants shared stressors related to the pandemic and its impact on their daily activities. A social worker participant described that during the COVID-19 pandemic, she had felt that the usage of personal protective equipment hindered the effectiveness of her counseling skills. She reported that one thing she had learned was the importance of checking for nonverbal cues and observing facial expression "so I feel that there is a barrier between myself and the patient and/or the family. Also, mentally I'm of course concerned about the reality of needing to keep my boundaries for my own safety as well."

The participant also reported that visitation restrictions had not been a positive experience for the workers, patients, or families. Another social worker in the study described how they now have to remember to ask specific questions about symptoms of patients and families before visits. Yet a third participant reported that as a social worker, they have been feeling ineffective doing the work by phone because of the inability to meet in person and observe nonverbal communication.

## Demographics

The participants ($N = 8$) were hospice social workers in the North Florida area.

The participants' work settings included home, in-patient, and long-term care, with some

working in all three settings. The participant ages ranged from 31 to more than 50. The

research called for social workers with at least 5 years of experience. The participants'

years as hospice social workers varied, ranging from 5 years to 23 years. All but one

participant was female. Table 1 provides demographic details on participants.

**Table 1**

*Background Information of Participants*

| Characteristic | N |
|---|---|
| Gender | |
| Male | 1 |
| Female | 7 |
| | |
| Age group | |
| 31-50 | 3 |
| 41-50 | 2 |
| 50+ | 3 |
| | |
| Years of experience in hospice care | |
| 5 | 2 |
| 9 | 1 |
| 9.5 | 2 |
| 16 | 2 |
| 23 | 1 |
| | |
| Setting | |
| Home | 2 |
| In-patient | 1 |
| Long-term care | 3 |
| All | 2 |

## Data Collection

I posed semistructured, open-ended questions to the eight hospice social workers

during their individual interviews. The purpose of the semistructured, open-ended

questions was to provide the participating social workers the opportunity to talk about their experiences and their feelings and the meaning and impact that those experiences have in their lives as hospice social workers. Purposive sampling was used to select hospice social workers for the study because have in-depth, rich knowledge and experience related to the phenomenon that was the subject of this research study (see Creswell, 2014; Ravitch & Carl, 2016; Thorne, 2016). The use of purposive sampling allowed me to deliberately select individuals with the experiences and information needed to answer the two RQs. I was able to interview eight participants, in keeping with the principle that the sample size of a qualitative study is usually small (Creswell, 2014).

The Walden University Institutional Review Board approved this study in June 2020 (approval no. 06-10-20-0570400). I sent a letter of intent via email to directors of hospices in North Florida requesting their cooperation in disseminating the intent for the study to their social workers; a letter of invitation to participate in the research study was included. The invitation to participate explained the specific condition of participation in the research and how to contact me. Once the participants contacted me, they were asked two questions to determine eligibility: first, if they have been working with hospice direct patient care for at least 5 years and, second, if they hold a supervisory position. During this process, I eliminated three potential participants as they did not meet the criteria for length of time working in hospice. I thanked them for reaching out and their willingness to participate. Those eligible to participate were emailed the informed consent and the request to email back if they agreed. Once I received the informed consent, I set up a date and time convenient to the participant for the telephonic interview. I called the participant

at the scheduled time and date, and before starting the interview I reminded the participant that the interview was confidential and that it would be recorded. I also reviewed the informed consent with the participant and collected verbal acknowledgment. Then, I collected demographic information. The interviews lasted from 25 minutes to 1 hour 10 minutes. An unusual circumstance encountered in the data collection in that I could not interview the participants in a face-to-face setting because of the current COVID-19 world pandemic.

The initial question was to understand how the participating social worker's day was structured. This question assisted me in understanding their day and what variables or similarities existed in participants' day-to-day work activities. The remaining questions were focused on eliciting information about participants' experiences regarding the two RQs. During interviews, the participants spoke freely about their experiences working with the terminally ill, compassion fatigue, how they view their quality of life is affected by their job, and how they cope working with death and dying daily. During the interviews, I used active listening and asked about their responses when I had some questions about my understanding of what they were conveying. After the interview was over, I thanked the participant and asked if they would be willing to participate in member checking; I made a note on the ones that agreed to it. Also, after the interviews, I reflected and wrote about my feelings and reactions to the interview. After the interview, I sent each participant a gift card of $10 from a coffee shop to thank them for their involvement in the study.

**Data Analysis**

I coded data manually using Microsoft Word. After each interview, I transcribed

the data verbatim and assigned a number to the interview. I personally transcribed the

data to further ensure the protection of the data. After the interviews were transcribed

verbatim into a Microsoft Word document, the interviews were listened to again to ensure

the accuracy of the transcription. The content analysis included coding to summarize or

condense the data (see Saldaña, 2016), identifying common themes and patterns in the

data in relation to the study's RQs. I used content analysis for this study, my first

qualitative study, because it allowed me, an emerging researcher, the opportunity to code

the data. The process allowed me to reflect on the participants' experiences.

I used generic qualitative analysis techniques to identify emerging themes in the

research. I read the interview transcripts a number of times to identify themes and

patterns for each interview question. While reading through each question, I highlighted,

bolded, and underlined keywords for the initial content analysis; then, I reviewed each

interview side by side and combined all themes and patterns of all the interviews on a

separate document. Themes and patterns were divided by each interview question,

resulting in 330 codes initially. Then on another separate sheet, I started reviewing the

data and analyzing the codes further. I reanalyzed the work, condensed the number of

codes, and developed a sense of categories (Saldaña, 2016) that led me to an

interpretation based on the participants' own words. Three participants agreed to member

checking, and a breakdown of themes and topics of their interview was sent via email for

their review. Table 2 presents results for RQ1, which was, What are the experiences

related to coping with death and dying?

**Table 2**

*Research Question 1*

| Theme | Code | Category |
|---|---|---|
| Theme 1: Experiences Are Influenced by the Setting of Their Job and the Length of the Relationship. | | |
| Feel stronger rapport when they are longer in the program | Time | Time on program |
| Someone I just met | Time | Length of time |
| The longer in the program, the more you connect | Time | Relationship development |
| Connection with the patient and the family | Relationship | |
| Seen one time | Time | |
| Development of rapport | Relationship | |
| Death of the relationship | Relationship | |
| Time in program influence | Time | |
| One-time visit | Time | |
| Few hours versus days | Time | |
| It depends on how long I've been with the patient. | Time | |
| | | |
| Theme 2: Maintaining Boundaries and Acknowledging Is Their Job and Helps With Coping. | | |
| Separation of work and home. | Boundaries | Coping mechanism |
| Self-protection | Boundaries | |
| Preparation | Anticipation | |
| Creating a barrier | Boundaries | |
| Not allowing myself to get close | Boundaries | |
| Sadness | Grief | |
| Limited bonding | Boundaries | |
| Normalization of death | Grief | |
| Detaching in love | Boundaries | |
| Anticipatory grief | Grief/Anticipation | |
| Acknowledge it's my job | Acknowledgment | |
| Creating a barrier | Boundaries | |
| Understanding is a calling | Acknowledgment | |

*(table continues)*

| Theme | Code | Category |
|-------|------|----------|
| Theme 3: Personal Losses Impact Their Grief. | | |
| Unexpected personal losses | Grief | Impact of death |
| Grieving own loss | Personal | Personal loss |
| Decision making for family | Personal | |
| Not having time to grieve | Grief | |
| Feeling numb | Physiological | |
| Giving permission to grieve | Acknowledgment | |
| Feels worst when is your family | Emotions | |
| Grieving differently | Emotions | |
| | | |
| Theme 4: Religious Beliefs and Faith Plays a Significant Role in Coping. | | |
| If I didn't have faith couldn't do the job | Faith | Religious beliefs |
| Spiritual relationship with God | Religious belief | influence coping |
| Recite Scriptures | Religious belief | |
| Faith | Faith | |
| Morning meditation | Coping | |
| Religious music | Religious belief | |
| Prayer | Religious belief | |
| Faith in God | Faith | |

Table 3 presents results for RQ 2, which was, How do participants' experiences affect their quality of life and their experiences with compassion fatigue?

**Table 3**

*Research Question 2*

| Theme | Code | Categories |
| --- | --- | --- |
| Theme 1: There Is a Positive Factor in How Their Jobs Affect Their Quality of Life. | | |
| Makes me a better person | Personal accomplishment | Views of |
| It's a calling | View of the job | positive factors |
| Feels good at the end of the day | Emotions | Emotional |
| Value family and relationships | Values | responses |
| Value time | Values | |
| Live life to the fullest | Personal motivation | |
| Enjoy life | Personal motivation | |
| Comfort level with death | Emotional coping | |
| More awareness to be present | Personal motivation | |
| Consciousness about living the day | Self-acknowledgmen | |
| Helps with own fear of death | Emotional coping | |
| | | |
| Theme 2: There is a Negative Factor in How Their Jobs Impact Their Quality of Life. | | |
| Negative feelings about fear of being chronically ill | Concerns | Physical and emotional |
| Fear of own health failing | Concerns | responses |
| Numbness to death | Physical impact | Job impacts |
| Constantly grieving | Emotional impact | mentally and |
| Realization of reality and fragility of life | Emotional impact | physically |
| Depression | Emotional and physical | |
| Anxiety | Physical/health impact | |
| Panic attacks | Physical/health impact | |
| Numbness to own pain during | Emotional impact | |

(*table continues*)

| Theme | Code | Categories |
|---|---|---|
| Theme 3: Compassion Fatigue Is Relatable. | | |
| Not caring for your needs | Physical/emotional | Physical and |
| Not self-caring | Physical/ emotional | emotional |
| Burnout is an outcome | Impact | responses |
| Decline in quality care | Emotional | Definition of |
| Negative thought about | | compassion fatigue |
| yourself/work | Emotional | How it develops |
| Frustration about own situations | External factors | |
| Stress imposed by company and | | |
| external systems | Development | |
| Progressive | Feelings | |
| Questioning line of work and | | |
| continuation | Development | |
| Can be sudden | Development | |
| Can affect you without knowing | Mental/physical impact | |
| Depression | Mental/ physical impact | |
| Anxiety | Mental/ physical impact | |
| Stress | Mental impact | |
| Overwhelm | Mental/ physical impact | |
| Overextension of yourself | Mental/ physical | |
| Psychosomatic kind of stress | Mental/physical impact | |
| Negative dreams | Physical impact | |
| Health gets affected | Impact | |
| Emotionally and physically wears | | |
| you off | Mental impact | |
| Becoming more than a job | Development | |

**Evidence of Trustworthiness**

**Credibility**

To improve the credibility or validity of the study, I utilized manual coding to ensure accuracy. Member checking (Creswell, 2014) was also utilized to improve validity and ensure credibility to the study. The participants that were willing to participate in member checking did accept the themes collected during their interviews and did not make any changes or suggestions.

**Transferability**

I transcribed all the interviews verbatim and double-checked that there were no mistakes during the transcription; this allows for reliability in the process. There were willing participants for member checking to determine the accuracy of the findings. I did send them a copy of the themes collected during their interview for review and acceptance (Creswell, 2014). Providing a thick, detailed description also mitigates transferability issues. It will allow others to have sufficient information about the study outcome and if they can be applicable to their particular situation and setting.

**Dependability**

Utilizing semi-structured questions provided dependability as the questions allowed hospice social workers to provide insight into the phenomenon by providing deep rich information about how they cope with death and dying daily, their understanding about compassion fatigue, and how their quality of life is affected. This information provided answers to the two RQs (Ravitch & Carl, 2016).

**Confirmability**

Because I have been working as a hospice social worker for the last 15 years, I kept a reflective journal of my experiences and feelings during the interviewing process and again while listening to the interviews for transcription. Writing the journal allowed me to explore my feelings and acknowledgment of biases as my feelings were emerging (Ravitch & Carl, 2016).

## Results

**Research Question 1**

RQ1 was, What are the experiences of hospice social workers related to coping with death and dying? Themes included the following:

1. Experiences are influenced by the setting of their job and the length of the relationship.

2. Maintaining boundaries and acknowledging is their job helps with coping.

3. Personal losses impact their grief.

4. Religious beliefs and faith play a significant role in coping.

### *RQ1 Theme 1: Setting and Length of the Relationship*

The first theme related to how social workers' experiences are influenced by their job setting and the length of their relationship with the patient. Social workers are able to describe their relationship with their patients as professional, maintaining boundaries, feeling accomplished according to the patient death, having created a barrier, self-protection, understating that the patient will die, connection, respect, dignity, detachment, disconnectedness, supportive, advocacy, comforting, reassurance, positive, therapeutic,

emotional connection, development of rapport, clear communication, engaged, present, compassionate, relationship of listening, and some grow closer. Depending on the nature and setting of their job, some patients are described as having a long relationship.

Participant 1 describes this experience as: "You have a stronger rapport with people that you care for a long time as opposed to someone that you just met once."

Participant 3 describes that due to the nature of the in-patient unit and that the patient might only go there for hours, there is no opportunity to connect with the patient or family. However, the intensity of the emotion might differ between settings as the participant discussed the difference of working on an in-patient unit where they see dead bodies daily and wonder if the experience might be different because of not seeing that part of death and dying as much.

Participant 4 describes that to be able to do the job effectively; there is some kind of connection with the patient. Participant 4 also clarified that there is a difference between connectedness versus emotional dependence.

Some patients are with us for a long time, and not just the patient but the family, and we develop a good rapport with each other and for that patient to die is also that that relationship has to die, you have to release that family and move on.

However, Participant 5 describes that because of the nature of the role because of not having a set setting, try their best to make an impact in each of the patients' lives but acknowledges that even when having limited contact with the patient and their family, still feels that with some patients,

some we become a little more attached than others. I don't get very emotional; I've

never been very emotional personally. When it comes to death and dying, I was

raised as that is a natural part of life, and it's nothing to really fixate over.

Participant 6 related that too,

Handle the death of the relationship for a lot of my patients is a relief for them

and their family, especially if it's been a long time. I've also experienced

tearfulness but never have been so connected that I could not be able to let go and

move on, I think I have developed that in my own practice, a sense of detaching in

love.

Participant 7 describes that the expression of grief "depends on how long I have

been with the patient and what the relationship is; sometimes I cry and sometimes I just

kind of be with myself and talk through it with myself."

Participant 8 reports that if the relationship with the patient has been a long one,

they have felt grief when they die. Although the relationship is a professional

relationship, "I think I just handle the death of the relationship."

### RQ1 Theme 2: Maintaining Boundaries

The second theme related to maintaining boundaries as a way of coping. Social

workers spoke about coping mechanisms used and their feelings, boundaries, separation

of work and home, self-protection, coming in knowing that the patient will die/

preparation, don't experience grief, creating a barrier, not allowing myself to get closer,

little sadness, empathy with the families, feeling good about being able to help the

families, limited bonding, sadness, tearfulness, glad they are not suffering, relief, prayer,

normalization of death, detaching in love, emotional but appropriately, handle the death of the relationship, anticipatory grief, and grief after death.

Participant 1:

I have that boundary up that where at the bed I can still have the relationship with patients and families, but I don't allow myself to get necessarily close enough or invested personally where I feel grief and loss the way I will with my friends and family and how I grieve my own losses. I have that boundary there; I think if I didn't have that, it will be hard to do the job and the work because I will have to constantly be dealing with the grief and loss of my patients. I guess that's a preventative way of coping with it, I don't know.

Participant 2:

Some you might feel kind of attached to the patient, but you can also maintain some kind of disconnectedness as well because you are going to lose them, so I try to just do what I can to be there for them and advocate for their need and their families.

Participant 3 reports that being aware of boundaries assists with the effectiveness of the job: "I'm of course concerned about the reality of needing to keep my boundaries for my own safety as well."

Participant 6 describes: "I have also developed in my own practice a sense of detaching in love; I have had patients and families in the past where it was emotional, but I will say appropriately emotional if that makes sense."

Participant 8 describes boundaries as sometimes you meet certain people and you establish a human connection, "I think I have some that I actually grieved."

*RQ1 Theme 3: Personal Losses Impact Grief*

The third theme relates to the impact of loss and coping with grief. Study participants expressed concepts related to existential coping such as spirituality, faith, value time, value family, value faith, moral conflicts between theology and ethics, looking too far into the future, understanding is a calling, personal and losses impact and intensify the grief.

Participant 2 reminisced about the year is particularly challenging because of unexpected personal losses, and having to assist with decision-making for the family provided a great deal of stress. "I think I was grieving her loss, and then at the same time, it's hard when you are working with people that are dying, and you are grieving your personal losses and trying to deal with the stress."

Participant 4 recalls the loss of a family member that actually died under hospice care and how that event impacted her as a hospice worker.

The decline was pretty quickly; while she was dying, I had to work through that, and I didn't have the chance to even grieve her death really because I'm trying to be there for my families, and I just felt very numb going through it like I just didn't give myself permission to grieve her death and to go thru that process, so that's when I knew I needed to take some time away,

as the participant reported started to doubt the effectiveness as a social worker as felt empty and unable to give any more to the patients or their own family.

***RQ1 Theme 4: Religious Beliefs and Faith***

The fourth theme related to the use of religious and spiritual beliefs and faith in coping.

Participant 2:

Really is just primarily for me is prayer, faith in God. If I didn't have faith in the Lord, I wouldn't be able to do this; I can tell you 100% that right now, I wouldn't be doing it. I mean, that's the driving force for me. I feel that's the reason that I'm there. I mean, it's like it's just caring about people and being interested. It's hard because it's like kind of a double edge thing because in your work environment you are supposed to keep your faith and your work separate, and there are ethical things as a social worker, you know, those kind of things, but then it's like as a person of faith you will have to stand those before God one day per your actions, and what you did and you didn't do.

Participant 4 describes coping with music but also,

My spiritual relationship with God helps me cope. If I feel it's a lot, I will take a moment out to say a prayer, listen to some music or recite scripture kind of thing. For me, that helps to center me, and a lot of times, even between patients, I have to do that a lot of times in between patients. I have to do that because if I go to a highly stressful patient's house, I don't want to take that stress to the next patient, so I try to release whatever is in between visits and begin fresh to the next.

Participant 5 describes coping as utilizing "The outlook in life, if you want to call it faith, I don't know what the word would be, just being realistic about it."

**Research Question 2**

RQ 2 was, How do their experiences affect their quality of life and their experiences with compassion fatigue? Themes included the following:

1. There is a positive factor in how their job affects their quality of life.

2. There is a negative factor in how their job impacts their quality of life.

3. Compassion fatigue is relatable.

*RQ 2 Theme 1: Positive Factors*

Social workers identified two ways that their job affects them, in a positive and non-positive way, but they also identified that the company has a role in how the job affects them. At the personal level, positive feelings associated with their job are: makes me a better person, it's a calling, feels good at the end of the day, the value of family and relationships, value of time, mindful of the little things, enjoy life, live life to the fullest, comfort level with death, more awareness of the present, conscious about living the day, help with own fear of death, more usage of self-determination, empowered to face the medical world, the realization of the fragility of life, and outlook on own mortality. A participant described her role as a social worker as some days being fulfilling and other days questions "why I'm here?"

Participant 1 describes as a positive impact feeling that is making a difference in others' lives:

There is plenty of days when at the end of the day, I feel good I did a good job; it is like a calling. It helps me feel satisfied. I try to remind myself of why I'm doing this job when I get frustrated with other stuff.

Participant 2 reports the job has changed their perspective about the value of time, family, and life.

> I think it changed me a lot. I think I look at life a whole lot different; I recognize that time is short and you can die at any time; life can change instantly. So I think it's really important to value your family, value your time, value your faith. I don't worry about the little things. I think it really has changed me for the better over the years.

Viewing as a positive that "we are helping people to have a positive transition and closure."

Participant 3 reports the positive impact of the job has been placing value to time.

> You value more the time with family.

Participant 4 reports that the hospice job had a positive and negative impact.

> I think it has done some good things, and it has done not so good things. If I look at how I am now. The good thing is that it has taught me to live my life and that you never know. To live my life to the fullest and enjoy life.

Participant 5 describes a positive impact of empowerment and the usage of self-determination in the medical field.

> In my personal life, I think it helps me. Like in my personal situation, I'm very analytical. I'm not afraid to ask questions anymore. Like when I go to the doctor either for myself or my family members, now I know the right kind of questions to ask, and I know that it's okay to argue with your doctor, that I don't have to trust them with blind faith. I recognize that I have the right to self-determination,

and I use it more than I ever did before. I feel that I have daily practice in how to

deal with stressful situations and difficult conversations and that sense of the

unknown, and I mean we all experience that in our own lives, but helping others

through helps me get through it on my own, and my family outside of work.

Participant 6 describes a positive impact in being conscious about the value of time and

some comfort about death and the reminder of own mortality:

Definitely, years of doing this have changed my outlook on my own mortality. I

hope that I have peace when it comes my time. Death is something that I talk

about every day; it's not like this elephant in the room. I have this comfort level

with death, I think, makes me more aware that all I have is the present moment,

that all I have is today, so it has helped me to be conscious about that, very

conscious.

Participant 7 describes a positive impact as a comfort level about death and facing own

mortality:

I can tell you; it has helped me with my own fear of death, believe it or not

because I actually never thought I would work for hospice; just happen to be I

was at a family death, and somebody said you should work for hospice and I tried

it, and I love it, so I think it has helped me learn how to deal with my own

mortality and death and dying of loved ones.

### RQ 2 Theme 2: Negative Factors

The negative impact was described as: depression, anxiety, panic attacks,

constantly grieving, grieving differently, suppression of sadness and grief, fear of own

health failing, fears of being chronically ill, continue to work during grief to numb personal grief, frequent thoughts about death and dying. Two social workers described organizational policies as a source of frustration, feelings of not being valued, burnout because of policies and not because of working with death, feelings of marginalization, burden with extra responsibilities.

Participant 1 describes a negative impact of the feeling of overwhelmed and unvalued; however, also describes a positive influence that compensates for the negative: "There is plenty of days when my job makes me feel frustrated because of politics and feeling marginalized as a social worker in the medical field." She also reported feeling unvalued by other disciplines because of the lack of understanding of the social worker's role and at times feeling that she is there because of Medicare's requirement and not because of the value that she brings to the table. But compensates her experience, "When I go and have a really good patient experience and do a really good job, then I think it is okay, that's why I'm here, so I try to refocus."

Participant 2 talked about a negative impact of facing own mortality and the negative impact of not feeling appreciated and being overwhelmed by the addition of administrative tasks.

Unfortunately, the other side of that is that I look too far into the future and then always think about my own passing. I feel that the unfortunate part of our jobs is from an administrative standpoint; I feel people say they appreciate you, but I don't feel that they totally appreciate us. I don't feel they have an understanding of

kind of how it's like to work in the front lines with death and dying day in and day

out.

The participant reports feeling that additional tasks that are imposed provide an extra

layer of stress and provides an example on how you could see pain and suffering on the

news, but you turn to a different channel and distract yourself but reports that in the

hospice work,

You want to distract yourself with something not negative, but in hospice, you

kind of have a hard time distracting yourself because it's in your face every day,

day in and day out, people are losing their loved one forever, and so,

unfortunately, you feel that they add things to the staff without realizing, that this

job is hard as itself. I don't quite understand their thinking behind as far as adding

more to the plate, to people that are already dealing with crisis every day.

Participant 3 describes the negative impact as fearing a sudden life-limiting illness

not only for the person but their own family: "Fear of chronic illness and the fear of

elements that could potentially happen to your own health I think it's a big part of how

affects me."

Participant 4 shared that the negative part is being "numb" about death and dying

and having difficulty grieving personal losses:

The bad part is that it had kind of made me numb to death, and I realize that it's

something that naturally happens, but I think it's really good to grieve and go to

the process of grief for people who are very close to you and I find that I have to

make myself do it like intentionally tell just myself; okay, you have to deal with

it, I can't just go on to the hospice social worker mode. In my personal life, I have

to figure out a better way to deal with it, so typically it works, but sometimes it

doesn't.

Participant 8 described a negative impact has been anxiety and thinking about death

frequently:

I will say in the last two years, I think it has been weighing on me more, till I get

to the point when sometimes I'm starting to have anxiety. I will realize that I'm

starting to think about death and dying a little too much, even with myself. It has

become more in that sense and having to have those thoughts about if that's me,

just thinking about in general a little bit more. If anything, it does kind of impact

my thought process a little bit more when it comes to death and dying on an

individual level.

### *RQ 2 Theme 3: Compassion Fatigue is Relatable*

The hospice social workers interviewed described compassion fatigue as follows:

not caring for your needs, decline in quality care, negative thoughts about yourself and

work, frustration about own situations, stress imposed by the company and external

systems, progressive questioning if they should continue doing social work, can be

sudden, can affect you without knowing, depression, anxiety, stress, being overwhelmed,

overextension of yourself, psychosomatic kind of stress, negative dreams, health gets

affected, emotionally and physically wears you down, feeling numb, feeling drained,

normalization about death and seeing a body, stop caring, frustration, not giving yourself

time to grieve, feeling empty, just doing the job, comes from listening and dealing with

complex topics, burdensome, dismissiveness, judgmental, not attentive listening, tiredness, becoming intolerant, tension, not as centered, lack of motivation, changes in eating habits, problems at home, becoming too emotionally involved, losing empathy, feeling the emotions the clients are feeling, shorter answers, becoming more than a job, can be sudden and affect you without knowing.

Participant 1 describes compassion fatigue as, "I think not providing the highest quality of care, negative thoughts that kind of bring down as far of quality of care. It could be also not giving yourself that self-care that you need."

Participant 2 described compassion fatigue as being progressive and the emotions as being overwhelming at times to the point when they had thought about leaving the line of work.

It's progressive; you don't realize how it is affecting you, your job, until you kind of get to that place when you feel like I can't handle this anymore or I can't do this anymore. I have found myself during the years questioning can I continue to keep doing this,

and reports that self-exploration and mindfulness plays an important role in self-checking one's own limitations to not end up in a place of burnout.

Participant 3 described the emotions changing as a starting to feel compassion fatigue when

It becomes more of just a job for us, where we can tend to forget, it becomes really easy and normal for us to talk about death and having seen a dying body taken off the unit, to walk into their room and seeing them taking their final

breath, the shock of the intensity of death and dying emotionally, physically it

starts to wear off, that's typically when I know that I'm fatigued.

Participant 4 described compassion fatigue as,

It's when you just kind of give of yourself so much you just kind of get numb to it,

and sometimes I feel that way; sometimes I need a break from the job, even if it's

not my regular time that I usually take off, that I just need a moment to get myself

back to caring.  Sometimes you just get to the point where you just do the job, and

the caring part of it goes away when I don't have more compassion to give to my

families or my patients.

Participant 4 describes that at that point, it becomes a moral conflict because the

reason the participant chose to work on hospice is to care for others and provide

compassionate care to their patients and families.

Participant 5 describes compassion fatigue as coming from listening to

Difficult topics that we deal with, you know, death and dying is a very emotional

burdensome field to be working" and describes as self-care as an important tool to avoid

compassion fatigue.

Participant 6 describes the feeling as "emotionally and physically drained" when

feeling compassion fatigue and reports that the amount of deaths plays a role in the

intensity of the compassion fatigue feeling.

I can physically and emotionally feel the drain, especially if there have been

multiple deaths that I have been actively involved with. I find that I can listen to

people's stories, for lots and lots of time, different stories, but if I have multiple, 2

or 3 families at the same time that are in the active dying process and working that, I can physically feel the toll that it takes on me emotionally because I feel that I'm not as centered and I feel it in my gut." When describing being "not as centered" the participant mentions not being as attentive listening, not present, tiredness, shorter with answers, not being as tolerant.

Participant 7 describes compassion fatigue as, "Will look like signs of depression, anxiety, lack of motivation, maybe not being as patient with people you are caring for, or it's a job."

Participant 8 describes compassion fatigue as: "When you become too emotionally involved with your client and empathizing and starting to feel some of that emotion of what they might be going through." Participant 8 describes that during the pandemic, compassion fatigue has been more relevant because of how unpredictable everything has become with the current pandemic, and reports that this year has felt that the job is affecting her coping in a manner that had never before affected her.

## Summary

RQ1: What are the experiences of hospice social workers related to coping with death and dying?

The experiences of hospice social workers have a wide range in variety, and coping is as individual as the participant, but some common aspects mentioned in the study were maintaining boundaries, self-acknowledgment of limitations, faith, meditation, prayer, taking time off, getting active, venting feelings with others, and

debriefing which assists in the day to day coping of working with death and dying. Some even report allowing themselves to cry helps them with coping.

RQ2: How do their experiences affect their quality of life and their experiences with compassion fatigue?

Social workers report that the effects of their experiences on their quality of life are twofold: positive and negative. They also report that compassion fatigue is described as relatable, and they were able to provide examples of how compassion fatigue looks for each one of them.

In Chapter 5, I discuss the findings and how they confirm, disconfirm, or extend the knowledge in our discipline by comparing them to the literature described in Chapter 2 and the findings in the context of the theoretical framework.

Chapter 5: Discussion, Conclusions, and Recommendations

**Introduction**

The purpose of this descriptive qualitative inquiry was to obtain a deeper and richer understanding on hospice social workers' experiences related to coping with death, the effects on their quality of life, and their experiences with compassion fatigue while working with death and dying daily in North Florida.

There were two RQs: (a)What are the experiences of hospice social workers related to coping with death and dying? and (b) How do their experiences affect their quality of life and their experiences with compassion fatigue? Four themes emerged for RQ1: (a) participants' experiences are influenced by the setting of their job, and the length of the relationship, boundaries, and acknowledgment that is their job helps them to cope; (b) participants' reminding themselves that this is the job they are called to do; (c) personal losses might impact the grief response; and (d) religious beliefs and faith play a significant role in coping. For RQ2, three themes emerged from the data, with the first two being that there are both positive and negative factors in how their job impacts their quality of life and the third being that compassion fatigue is relatable.

**Interpretation of the Findings**

The study provides insight into how working with death and dying daily impacts the quality of life of hospice social workers and how these workers cope with it. Secondary trauma is a risk for social work professionals, and the degree to which it affects their quality of life and how they cope is as unique as the individual, concurring

with Lazarus (1993) that coping is not a universal response to a situation but more of an individual response to a situation. Similarly, Alkema et al. (2018) noted that compassion fatigue or secondary trauma was more of an individual response related to the client's experiences with suffering and trauma. Mathieu (2012) described compassion fatigue as an occupational stress response in health care providers, while Chan et al. (2015) included palliative care workers. Some study participants described the occupational stress very well as they talked about feeling that organizational requirements, changes, and expectations provided a source of stress that were not directly related to listening to the suffering of the patients.

One participant (Participant 2) stated that hospice work challenges "your own thought about death because you are so much more exposed to it every day, and so for me, I think I went through a period of depression and anxiety, just kind of learning how to cope with my own life." During this study, some participants identified the feeling of compassion fatigue as not being able to provide the highest quality of care; feeling psychosomatic stress that resulted in physical illness, numbness towards dying, and the feeling of not caring; and looking at the job as a job and feeling remorse about not caring as they used to or felt as they used to, a feeling that can be classified as moral distress. At that point, the participants stated that they refocus and take time off or are more deliberate in taking time for self-care, which is done as a self-preservation method. Mota Vargas et al. (2016) referred to compassion fatigue as an emotional state that also has physically and psychologically negative consequences. Participating hospice social workers provided examples of positive and negative aspects that included how

compassion fatigue affected them psychologically and physically. Participant 6 reported noticing a change in emotional status after experiencing  multiple patient deaths, saying "I find that I can listen to people story" and "If I have been in multiple like 2 or 3 at the same time that are in the active dying process, I can physically feel the toll that takes on me and emotionally because I don't feel as centered." The participant also reported that they started to have inattention, as exemplified by "not feeling as present," being "shorter in answers," and physically feeling "tenseness in my gut."

Diaconescu (2015) argued that the helping professionals should have self-awareness of their abilities, attitudes, exposure to suffering, and organizational environment as this will assist the social worker in mitigating or preventing burnout. The participants in this study were able to identify several methods they used for self-care, including making a conscious decision about separating work and home, venting feelings, creating boundaries, self-acknowledging limitations, exercising, resting, debriefing, adequate diet, "taking mental health days," processing, relaxing, praying, having quiet time, and reading the bible to mention some. Figley (1995) stated that compassion fatigue is difficult to anticipate and sudden. This assertion differs from the description given by one of the participants (p 2) about how they feel compassion fatigue, which is as a gradual process that culminates with burnout if unattended. The participant stressed the importance of being hypervigilant and self-aware about emotions and feelings daily and to act on self-care regularly.

Figley (2016) noted that the main channel for secondary traumatic stress is empathy and the empathic concern of helping professionals and that the more the

professional is engaged emotionally, the greater the probabilities for personal distress.

The participants in this study identified that the length of time the patient is in the

program would impact their emotional connection and their emotional response at the

time of the patient's death. Social workers in the study talked about their experiences

working with patients and their families for very short times, sometimes hours, versus

working with them for a more extended time that could extend to a year or more. The

social workers identified that the patients who were in the program for a shorter time did

not impact their emotional response to their death versus the ones that they got to know

and know their families. Some reported that for those whom they cared for the longest,

they felt some sadness, tearfulness, or grief or got emotional ("but appropriately

emotional"). A social worker participant reported a distinction between the feeling of

grief when a patient dies versus the grief felt when one of their own family members dies.

One of the participants said that a mechanism to cope with the death of patients who they

have served longer was to assist at the funerals as this provided a method of closure of

the relationship. Others identified that self-protection, boundaries, and "not allowing

myself to get too close" were mechanisms for coping with the death of those

relationships. Self-awareness and understanding that the professional relationship will

come to an end, in addition to detaching, or, as one participant identified, "detaching in

love," and boundaries, assisted them with coping. These findings correlate with the

NASW (2017) Code of Ethics that boundaries are maintained as an ethical behavior to

protect the client and to contribute to the quality of life of social workers . Furthermore,

as Avieli et al. (2015) stated, the social worker can maintain empathic engagement while

maintaining boundaries, and that this could be a behavior that could help with the minimization of secondary traumatic stress.

The transactional theory of stress and coping, the conceptual framework of this study, defines coping as a person's efforts to respond effectively to the challenges of a stressor and manage external or internal demands (Folkman, 1984; Folkman et al., 1986). Coping is the individual's effort to manage psychological stress (Lazarus, 1993), and according to the theory, coping can be classified as adaptive or maladaptive. Hospice social workers respond daily to challenges and manage not only external but internal demands. Craig and Sprang (2010) noted that there can be an optimum stress level; however, when the stress becomes excessive, it will challenge the effectiveness of the professional. In analyzing the data from the study, I found a correlation between the relationship of how social workers view their job and how their job affects their quality of life while understanding how they cope with death and dying. Because of the nature of mental health professionals' work, there is a potential that stress could become excessive, placing the professional at risk for compassion fatigue (Figley, 1995). Folkman (1984) observed that events that could be seen as controllable did not necessarily indicate stress reduction. This study showed that the participants have ways to cope with death and dying, and although those coping mechanisms were effective, they did not necessarily indicate that their stress was reduced. Participant 2 reported that hospice has challenged their thoughts of death and dying and that in retrospection, they can see where in attempting to manage the stress of coping with the job, they went through a period of depression and anxiety as they attempted to learn how to cope with their own life. During

this time, they often felt overwhelmed, which led the participant to question if they could continue watching people not only die but seeing people suffering and grieving every day.

Social workers in the study were able to describe positive and negative emotions along with positive and negative impacts of their jobs on their quality of life. These findings concur with Folkman and Moskwitz's (2004) assertion that negative appraisals are accompanied by negative feelings; however, challenges are seen as possibilities to overcome, although it could bring failure. In that case, the emotions could be positive or negative. Some social worker participants described the positive aspects of the job by reporting that it fulfills their mission as feeling good doing the job and knowing that they could help not only the patient but also the family unit. Some other positive factors that were identified during this study were feeling good about their job at the end of the workday, valuation of family, relationships and time, being mindful about life and the fragility of life, trying to live their life to the fullest, making attempts to be more present in their relationship, being conscious about their daily living, and helping them with their own fear of death. On the other hand, social worker participants described the negative feelings as having depression, anxiety, panic attacks, fear of their own health failing, fear of having a family member diagnosed with a terminal illness, fear of being chronically ill, and recurrent thoughts about death and dying. However, the social worker participants who identified those negative feelings were also able to identify strategies to be more aware of their feelings to strategize self-care.

Lazarus (1993) classified cognitive and behavioral effort to manage stress as adaptive or nonadaptive. The adaptive component is a component that achieves a way of coping and improves outcomes. The adaptive component may align with resilience, which, according to Mota Vargas et al. (2016), is the ability to cope with continued stress resulting in future improvement as a professional. This concurs with this study's findings regarding participants' comments about negative feelings: that they do have negative feelings but adapt their way of coping to improve the results. Professionals could rise beyond the adversity they face while continuing to have a capacity for compassion. Positive emotions can result amid the stress and provide a strength that they can access during stressful situations (Gentry & Diez, 2020); this is also known as resilience.

## Limitations of the Study

### Credibility

I made no changes from the proposal to the implementation of this study. I used manual coding to ensure that the codes were accurate, and I used deep, rich descriptions of the data to affirm that the findings were faithful to the participants' experiences (see Creswell, 2014; Ravitch & Carl, 2016). Member checking was used to ensure the credibility of the study (see Creswell, 2014).

### Transferability

No changes arose from the execution of the study. There were willing participants that agreed to participate in member checking; this allowed the researcher to determine the accuracy of the findings (Creswell, 2014).

**Dependability**

A qualitative method was utilized to answer the two RQs. This allowed the participants to provide rich information about how they cope with death and dying, how they deal with compassion fatigue, and how it affects their quality of life. The participants' sample was expected to be between 8-10, and the research was done with eight participants. The interview questions provided dependability as they were targeted to answer the RQs (Ravitch & Carl, 2016).

**Confirmability**

I wrote a reflective journal that allowed me with the opportunity to explore and acknowledge any possible biases onto my interpretations (see Ravitch & Carl, 2016). I reflected on my experiences as a hospice social worker, values, and my assumptive world. The journal helped me keep my feelings apart from the research and be objective, promoting self-reflection on my personal beliefs and not allowing them to affect my analysis process.

<div align="center">

**Recommendations**

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Recommendations for future research include expanding the research on compassion fatigue and coping with death to other hospice professional groups such as doctors, chaplains, nurses, advance nurse practitioners, and bereavement counselors. This will provide a deeper understanding of the similarities or differences in coping mechanisms across hospice professionals. These professionals also working with hospice patients that have been affected by trauma are not exempt from being vicariously affected by those experiences (Caringi et al., 2017) and, according to literature, compassion

fatigue has long been an occupational stress response in health care providers (Mathieu, 2012) and palliative care workers (Chan et al., 2015); this phenomenon appears to increase amongst health care workers (Harr & Moore, 2011; Klein et al., 2018).

This study was conducted in the North Florida area. I would recommend that research be expanded to a state-level or other states to evaluate differences and similarities. Research to be broadened to hospice social workers with less than 5 years of experience to research whether there is a difference in the prevalence of compassion fatigue and their coping with death for social workers in the earlier stages of their careers working with hospice.

## Implications

This generic/basic qualitative inquiry provided insight into the specific needs of hospice social workers by understanding their experiences about compassion fatigue and providing insight about what they view as a need for support. On an individual level, it provided an outlet for hospice social workers to reflect on their job and how they manage their day-to-day experience with death and dying. On a family level, it provided the opportunity for the participants to understand and reflect on the support that they receive informally from family members and friends, but not only that it made them think about how their families are affected when they are not coping with their job as their compassion fatigue directly impacts them. Some participants reported that their families sometimes point out their changes in behavior before they recognize those changes. On an organizational level, it provided insight about what social workers perceived as an organizational hindrance on support to the social workers. During this

research, some of the participants discussed feelings of being unsupported by the organization in meaningful ways and how organizational policies add an extra stressor to their daily activities. Understanding these issues will help others consider what social workers perceive would be a meaningful way to support them to continue to do the work they do daily.

### *Methodological Implications*

A generic qualitative design was considered the most appropriate method for this study (Kalhke, 2014; Percy et al., 2016; Ravitch & Carl, 2016; Thorne, 2016) which allowed the participants to openly discuss their experiences while making meaning of their experiences (Patton, 2015); Ravitch & Carl, 2016). Social workers were able to provide their own perspectives and experiences in the context of how they view those experiences.

### *Recommendations for Practice*

This research provided insight into the hospice social workers' experiences with coping with death and dying daily and how it affects their quality of life. The needs that hospice social workers perceive affect their coping and quality of life. One of the questions asked during the interviews was, what kind of support is available to them to carry out their work? As far as support for hospice social workers, all participants in this study agreed that there is no formal support for social workers to help them cope with their work. Three participants reported they have access to the employee assistance program but, when used, they have not found it helpful. One participant noted that they only had access to two visits, which was perceived as not enough time to be able to

process. Five participants have access to an employee assistance program but have never used it. As social workers, however, they where able to describe some informal support, such as supervision, if you are required to do so for licensing; unfortunately, per the social workers, supervision is required for social workers that are seeking licensing and not required for others who either already have their license or don't want to seek licensure. Some social workers identified some management support, team meetings, and family support. Research had suggested supervision as a strategy to help the workers to cope with stress. However, within the scope of this research, the participants described that if they did not need supervision for their licensure, there was no formal support where they could sit and talk about their experiences as they expressed that managers or supervisors were only supportive for patient-related issues, not for the acknowledgment of their relationship with those patients and families' deaths and the social workers' grief. Other themes were no moral support; not feeling they have support from the National Association of Social Workers; no community support; limited connection with co-workers because of the individuality of the work. Participants also discussed the need for resources to assist the worker when a patient dies because of suicide was brought up during the interviews.

Hospice social workers identified that a gap they feel is that they do not have formal support available to them. Hospice organizations could look at how they can better support their social workers. A recommendation is that hospices will provide supervision for all staff not only to discuss patient's concerns but to debrief and talk about their emotions and concerns. If supervision is not a possibility, then hospices could

research having a part-time hospice social worker that has experience working on direct care to provide support to the hospice social workers. Peer support might be the best tool to support social workers and should be looked at to prevent compassion fatigue and burnout. This will mitigate the gap of not having a formal support system and will void the issue of not having a specific amount of time that the benefit can be accessed and will provide a safe/confidential place to process feelings. This continual, consistent assistance will eventually be cost-effective as it will mitigate the feelings of not wanting to continue in the line of work, will prevent burnout, psychosomatic symptoms, and will be helpful to increase resilience. It will provide an outlet of self-care and self-preservation that otherwise is not readily available.

## Conclusion

This qualitative research provided an opportunity for hospice social workers to offer insight into their job, how they cope, their understanding about compassion fatigue, and how their hospice work impacts their quality of life. Understanding their needs, we are better positioned to support them and help them, just as they do for others daily. During this qualitative research, hospice social workers were opened to discuss their feelings, experiences, concerns, and perceived support or the lack of support to help them cope with their daily challenges and compassion fatigue. Hospice organizations should consider this information as they seek to provide services to their patients. They should consider revising the support currently offered to the hospice social workers to devise other ways to support them in a more meaningful way throughout their careers.

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Appendix: Interview Questions

Demographics

This data is required for research purposes and **not** to identify the respondents.

Age:

1. 20-30

2. 31-40

3. 41-50

4. 50+

Gender:

Male

Female

Other

Years of experience as a hospice social worker: _____

**Interview questions:**

1. How is your day as a Hospice Social Worker?

2. What do you understand about compassion fatigue? Can you give me an example?

3. How do you manage difficult and emotionally taxing days?

4. How would you describe your relationship with your patients?

5. What do you experience when one of your clients die?

6. Can you give me an example on how you grieve the death of a client?

7. How do you recognize and manage your grief?

8. What do you do to cope while facing death and dying daily?

9. How do you feel your job affects you as an individual?

10. What support, if any, is available for hospice social workers to help you cope?

11. Is there something that you would like to talk about related to your experience that

   I did not ask about?