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Exploring the Experiences of Hospice Human Service Professionals Caring for Terminally Ill Patients

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Abstract

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by

Cynthia Renee Rector

MA, Capella University, 2013

BS, Dallas Baptist University, 2003

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Hospice human service professionals have a special responsibility to help people who cannot help themselves, such as individuals with terminal diagnoses. The purpose of this descriptive phenomenological study was to explore the lived experiences and self-care practices of hospice liaisons and social workers who work in high-stress environments and who assist with personal care for terminally ill patients. Orem's theory of self-care provided the framework for the study. The data were collected using semi structured face-to-face interviews with a sample size of seven hospice liaisons and social workers who assist individuals who need hospice services. I employed Colaizzi's seven steps for analyzing phenomenological data, and extracting rich, descriptive data from the interviews. Three themes emerged. Theme one revealed that hospice work was overwhelming, stressful, and caused burnout, aggravated by some workplaces lacking necessary resources. Theme two captured self-care activities that hospice social workers practiced for self-care, including maintaining boundaries from work, doing activities of personal interest, creating time to recharge, leaning on support groups, and living a healthy lifestyle. Theme three also revealed that hospice social workers encountered compassion anxiety and vicarious trauma from interacting with terminally ill and suicidal patients. The three themes supported theory propositions that individuals perform certain practices for survival and to safeguard their wellbeing. The results of the survey concluded that hospice social workers and liaisons should put their own health first because doing so will help them fulfill their positions and obligations more successfully.

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Chapter 1: Introduction to the Study

Introduction

According to the U.S. Bureau of Labor Statistics (BLS, 2015), the need for hospice workers was expected to grow 27% between 2012 and 2022. Hospice social workers are human service professionals who assist with personal care for patients who have been given a prognosis of 6 months or less to live (Head et al., 2019). Hospice liaisons are human service professionals who provide hospice information to patients and the families of patients who are expected to be referred to hospice (Livne, 2014). Human service professionals who work in hospice care often struggle to balance their self-care with the needs of patients (Eaves, 2018). High rates of burnout (Cetrano et al., 2017), death anxiety (Quinn-Lee et al., 2014), compassion fatigue (Cetrano et al., 2017), and vicarious trauma (Pelon, 2017) are common among hospice workers.

According to Bennett (2018), hospice social workers and liaisons often face complex emotions related to interpersonal relationships with patients, including stress and separation anxiety, where their self-care may become secondary as it relates to job responsibility and personal health. Like other professionals who work in high-stress environments, hospice care workers can also experience an increased risk for workplace injury (Cetrano et al., 2017), decreased concentration (Eaves, 2018), impaired cognitive (Castiglione et al., 2016), poor self-esteem (Galanakis et al., 2016) sleep disorders (Kwong, 2016), health-related problems (Kwong, 2016), and poor mental health (Grise-Owens & Eaves, 2018; Kwong, 2016).

Hospice care workers who embrace and practice proactive self-care may avoid some of the adverse effects of working in high-stress environments (Xu et al., 2019). However, a lack of self-care may result in burnout, attrition, and decreased patient care (Xu, et al., 2019). Although there is research regarding self-care of doctors, nurses, and other healthcare professionals, little is known about the lived experience of self-care among hospice social workers who work in high-stress environments and who assist with personal care for patients who have been given a prognosis of 6 months or less to live (Adima00ndo, 2018; Crane & Ward, 2016; Halm, 2017; Kumar & Cavallaro, 2017; Mills & Chapman, 2016). Hospice social workers and liaisons who work in high-stress environments and who assist with personal care for terminally ill patients are possibly at risk for experiencing complex emotions, higher attrition rates, and reduced quality of care for themselves and their patients. I have that focuses on the lived experience and self-care practices used by hospice social workers and liaisons who care for the terminally ill (i.e., residing in senior-care living centers, nursing facilities, hospitals, and personal residences), leaving a research gap in the literature.

Background

Hospice is a unique care model for individuals who are in the late phase of life, have an incurable disease, and desire to receive end-of-life care at home or in a specialized care setting (Harris-Kojetin et al., 2019). Hospice care is essential to providing dying patients with comfort, prioritizing quality of life, and offering pain management to reduce patient suffering (Skinner et al., 2015). A hospice social worker's role depends on patients’ needs (Kuhn & Flanagan, 2017). The services that hospice social workers provide are broad, including direct care services, clinical services, and psycho-social services (Silverman, 2016). Similarly, hospice liaisons typically establish relationships with patients, families, and nurses, providing informational meetings to walk patients through the difficult process of terminal diagnosis and curative care (Livne, 2014).

Orem (1991) defined self-care as a set of ongoing activities that maintain and promote a healthier way of living. Self-care practices can empower an individual to negotiate overall health, wellbeing, and resilience in a proactive manner (Miller et al., 2017). Self-care offers an empowerment mechanism to exert agency over health and wellbeing (Pope et al., 2017). To understand the challenges of self-care in hospice social workers, it is necessary to provide a brief background regarding self-care.

Problem Statement

The problem that I address in this study is the growing need for hospice social workers and liaisons, and the lack of understanding regarding the self-care practices among these professionals. As life expectancies increase alongside the rise in chronic, life-limiting conditions, demands for hospice workers have soared (Kamal et al., 2020). Because of the nature of hospice work, high rates of burnout (Cetrano et al., 2017), death anxiety (Quinn-Lee et al., 2014), compassion fatigue (Cetrano et al., 2017), and vicarious trauma are common hospice workers (Pelon, 2017).

Although research exists regarding self-care of doctors, nurses, and other healthcare professionals (Mills et al., 2018), little is known about the lived experience of self-care among hospice social workers and liaisons. Specifically, a gap exists in understanding the lived experiences of hospice social workers and liaisons who work in high-stress environments and provide care to patients who have been given a prognosis of 6 months or less to live (Adimando, 2018; Crane & Ward, 2016; Halm, 2017; Kumar & Cavallaro, 2017; Mills & Chapman, 2016).

Purpose of the Study

The purpose of this descriptive, phenomenological study is to understand the lived experiences and self-care practices of hospice social workers and liaisons who work in high-stress environments, and who provide care to patients who have been given a prognosis of 6 months or less to live. Grise-Owens et al. (2017) indicated that perceived health status and current financial situations were significant predictors for overall self-care practices. Further, Dickson (2018) agreed that self-care was vital to hospice professionals who worked in high-stress environments, and Haley (2019) advocated that social worker who lack self-care are not able to perform or provide viable services to their clients. Through this study, I explored the lived experiences of hospice social workers and liaisons who provide care to terminally ill patients to understand their self-care practices.

Research Question

The following research question supports the problem focus for this study:

RQ1. What are the lived experiences and self-care practices of hospice social workers and liaisons who work in high-stress environments and who assist with personal care for terminally ill patients?

Framework

The theoretical base for this qualitative phenomenological study was the self-care theory (Orem, 1991). According to Orem (1991), self-care describes human interaction and the ability to learn and apply the principles related to caring for oneself. Self-care theory provides an understanding of the core belief for human interaction. Self-care includes ongoing activities that maintain and promote a healthier way of living. A metaparadigm in health, according to Orem (1991), includes physical, mental, and social well-being, as well as the integrity of the human structure.

According to Orem (2001), the broad approach is “the act of aiding others in the supply and administration of self-care in order to maintain or improve human functioning at home.” Orem’s idea is centered on each individual and “the practice of activities that individuals initiate and carry out on their own behalf in order to maintain life, health, and well-being” (2001). Because the aim of the proposed study is to understand the lived experiences and self-care practices of hospice social workers and human service professionals, self-care theory provided a valuable lens for understanding and interpreting participants’ experiences.

Nature of the Study

I used a descriptive phenomenological approach to explore the experiences of hospice social workers and liaisons who work exclusively with terminally ill patients. The phenomenological approach is concerned with exploring participants' interpretations and understandings of their lives and providing their perspectives of what is being examined (Moustakas, 1994). The descriptive phenomenological approach draws from the seminal work of Giorgi (2009), who extended Moustakas's (1994) approach by directing researchers to bracket their experiences and preconceived notions as they developed descriptive detail about a phenomenon experienced by research subjects, of which the subjects may be unaware. Previous researchers have employed a descriptive phenomenological approach to understand the phenomenon of stress and self-care (Adimando, 2018; Crane & Ward, 2016; Halm, 2017; Kumar & Cavallaro, 2017; Mills & Chapman, 2016).

Data were collected via individual, semi structured interviews with hospice social workers and liaisons. Interview data were analyzed following the procedures described by van Manen (1990) and Colaizzi (1978). The focus of my research is to explore the lived experiences and self-care practices of hospice social workers and liaisons who provide personal care to the terminally ill. Additional details regarding the phenomenological approach are provided in Chapter 3 of this dissertation.

Definitions

Burnout: The term burnout is mentioned throughout this study as a description of including exposure to excessive loss and difficulty coping with emotional responses to those losses (Slocum-Gori et al., 2013).

Compassion fatigue: Figley (1995) defined compassion fatigue as a deep awareness of others' suffering, along with a desire to relive their suffering. Compassion fatigue has also been defined as tension and preoccupation with the traumatic experiences of others, which can cause individuals to relive trauma and to avoid situations or people that remind them of the trauma (Portoghese et al., 2020).

Death anxiety: In this study, the term death anxiety describes concerns about the denial or fear of death, avoidance of death, and reticence to interact with dying individuals (Mallett et al., 1991).

Hospice: Harris-Kojetin et al. (2019) defined hospice as a unique care model for individuals in the late phase of life with an incurable disease who wishes to receive end-of-life care at home or in a specialized care setting.

Hospice liaison. Hospice liaisons are human service professionals who provide hospice information to patients and families of patients who are entering palliative care (Livne, 2014).

Hospice social worker (HSW): Hospice social workers are individuals who provide personal care to patients who have been given a prognosis of 6 or fewer months to live (Head et al., 2019).

Resiliency: Resiliency refers to the capacity to recover from difficult circumstances (Melvin, 2015).

Self-care: According to Orem (1991), self-care describes human interaction and the ability to learn and apply the principles related to caring for oneself. Self-care includes ongoing activities that maintain and promote a healthier way of living (Orem, 1991).

Vicarious trauma: Vicarious trauma is a process in which individuals who work with those who have experienced trauma become so entrenched in helping others that they begin to feel the trauma themselves (Pereira et al., 2011).

Scope and Delimitations

The scope of the study is limited by the sample, which consists of hospice social workers and liaisons who work in the following facilities: hospital, senior nursing facility, or home care. This sample allows me to explore the lived experiences and self-care practices of hospice social workers and liaisons who work in high stress environments and assist with personal care for terminally ill patients. Other caring professionals who work with hospice patients, such as doctors, clinicians, and nurses, are not included in this study. Due to the small, nonrandom sample of participants, findings from this study may not be generalized across broader populations. Other delimiting factors include my choice of study design and framework.

Assumptions

In this descriptive phenomenological research study, I explore experiences of hospice social workers and other human service professionals who work with terminally ill patients. My first assumption for this study is that my participants will be open and honest about their experiences with self-care. Second, I anticipate that the study participants will remember specifics about their encounters. Third, I anticipate the participants being willing to talk about the intricacies of their current self-care practices.

Limitations, Challenges, and/or Barriers

This study has limitations related to methodology, sample size, and researcher bias. The challenge of qualitative research is to ensure rigor because the research occurs in a natural setting; therefore, replication may not be easy to accomplish (Simon & Goes, 2013). Qualitative studies may also have smaller sample sizes than quantitative studies (Emmel, 2015). Phenomenological designs have sample sizes that may be generally small but yield thick and rich data, as the point is not generalization across a population. These data can lead to insightful themes and possible theoretical saturation, helping to ensure the reliability and validity of the study (Cypress, 2017; Emmel, 2015).

Qualitative studies can also have limitations, such as researcher bias (Giorgi, 2009). Researcher bias includes partial perspectives that favor certain populations or opinions (Gao, 2020). However, by using the approach of bracketing, I journaled (crafted memos) my thoughts to manage any biases that occured while conducting the study (see

Giorgi, 2009). By journaling, any preconceived notions, opinions, or biases can be recognized so that I may set them aside while conducting work on this investigation.

There are a number of barriers that can occur throughout the data collection process. In this study, due to the sensitive matter of the phenomenon and because the problem cannot be directly observed, I must rely on the data collected from study participants during the interview. The barriers that may be encountered within this study relate to the private and intimate context in which compassion death often takes place (Way & Tracy, 2012). They can occur in the form of ethical concerns, participants' accessibility, and time to collect data from study participants.

Significance

Findings from this study may help researchers understand how hospice social workers and liaisons care for their personal wellbeing in professional settings. Additionally, illuminating this social phenomenon may assist researchers in understanding the social complexities that result from a lack of self-care among hospice professionals. Findings from this study could increase awareness for hospice social workers and liaisons by providing insights that lead to the development of materials used for training or seminars. If hospice social workers and liaisons are adequately trained to recognize and deal with stressors and practice good self-care, they are less likely to experience adverse outcomes (Ebadi et al., 2016; Maley, 2018). The insights gained from this study can also be shared at professional conferences for hospitals, senior care living facilities, and private residences administrators, and hospice care providers. Finally, self-care practices learned from the hospice social workers can be shared with the research community at scientific meetings, thereby contributing to social change.

Summary

Demands for hospice workers are expected to grow considerably as life expectancies increase alongside the rise in chronic, life-limiting conditions (Kamal et al., 2020). The nature of working with sick and dying patients creates high rates of burnout (Cetrano et al., 2017), death anxiety (Quinn-Lee et al., 2014), compassion fatigue (Cetrano et al., 2017), and vicarious trauma among hospice social workers and liaisons (Pelon, 2017). While self-care practices may help circumvent the negative effects of working in hospice care settings, little is known about self-care among these professionals. Accordingly, the purpose of this descriptive, phenomenological study is to understand the lived experiences and self-care practices of hospice social workers and liaisons who work in high-stress environments and provide care to patients who have been given a prognosis of 6 months or less to live. The study is guided by a single research question and is framed by Orem's (1991) self-care theory. Data was collected via semi structured interviews with hospice social workers who provide personal care to the terminally ill. Findings may help researchers understand how hospice social workers practice self-care and potential opportunities for improvement in these practices.

Chapter 2: Literature Review

Introduction

The purpose of this descriptive, phenomenological study is to explore the lived experiences and self-care practices of hospice social workers and liaisons employed in high-stress environments and who work with terminally ill patients. According to the BLS (2015), the need for hospice workers was expected to grow 27% between 2012 and 2022. Because hospice social workers may struggle to balance their own self-care needs with the needs of their patients (Eaves, 2018), these professionals often experience high rates of burnout (Cetrano et al., 2017), death anxiety (Quinn-Lee et al., 2014), compassion fatigue (Cetrano, et al., 2017), and vicarious trauma (Pelon, 2017). Self-care practices may mitigate the negative effects of working in hospice settings; however, little is known about the self-care practices currently employed by hospice social workers and liaisons.

The chapter begins with the literature search strategy process used to locate peer-reviewed literature discussed in this chapter. Next, the conceptual framework is discussed. A review of the related research follows, beginning with discussions of hospice, hospice social workers, and hospice human service professionals. Risks to hospice workers and hospice human service professionals who work with terminally ill are presented next, including burnout, compassion fatigue, death anxiety, vicarious trauma, secondary traumatic stress, and turnover. Self-care practices are reviewed, including compassion satisfaction, spirituality, humor, mindfulness, and exercise. Self-care includes ongoing activities that maintain and promote a healthier way of living. Finally, the research gap that to be addressed in this investigation is discussed. The chapter ends with a summary of the significant literature specific to this study.

Literature Search Strategy

The literature reviewed in this chapter were located using online databases through Walden University Library including EBSCO, PsycINFO, ERIC, Sage, SocINDEX, and Thoreau Multi-Database search. I searched for peer-reviewed articles published during or after 2015 using the following keywords: *hospice social worker (HSW), hospice liaison, burnout, compassion fatigue, death anxiety, dying, hospice, medical social worker, resiliency, self-care, self-care theory,* and *vicarious trauma.* In addition, the following combinations of search terms were used: *burn-out AND hospice social worker, compassion fatigue AND hospice social worker, death anxiety AND hospice social worker, hospice social worker AND medical social worker*, and *vicarious trauma AND hospice social worker.* To ensure the scholarship discussed in this chapter was both recent and timely, I focused on literature published after 2015. Older, seminal studies have only been included as appropriate, to provide a more holistic and historic examination of the topic, and to support and describe the theoretical framework. A total of 108 resources were used in this chapter.

Conceptual Framework

The conceptual framework for this qualitative phenomenological study is the theory of self-care. Self-care theory is one of three interrelated constructs that comprise

Orem’s (1991) self-care deficit theory of nursing. The other two are self-care deficit theory and the theory of nursing systems. Because the aim of the proposed study is to explore the lived experiences and self-care practices of hospice social workers and liaisons, self-care theory will provide an appropriate and helpful research foundation.

Theory of Self-Care

The theory of self-care provides a construct for understanding human interactions and the ability to learn and apply principles related to caring for the self (Orem, 2001). Over the course of four decades, Dorothea Orem’s general theory of nursing emerged out of her own work and collaboration with students, practitioners, researchers, educators, administrators, and academics. Orem started her research by looking for distinctions between nursing and other occupations. According to Dorothea Orem, every human being is required to perform certain tasks in their daily lives that are critical to their survival, and these tasks are referred to as selfcare (2001). Self-care deficiency occurs when a person is unable to complete a task on their own or without the assistance of another person (Orem, 2001). Surprisingly, a person does not require the assistance of a nurse during self-care, but when a deficit occurs, the nurse intervenes and attempts to correct the deficit by partially or totally completing the work if the client is too dependent. Orem also considered the people who care for individuals at home or in families, which she categorizes as dependent care theory (Orem, 2001).

Self-care is used to describe the performance or practice of activities that individuals initiate on their own behalf to maintain life, health, and wellbeing

(Abotalebidariasari et al., 2016; Denyes et al., 2001). According to Orem (1991), a metaparadigm in health encompasses physical, mental, and social wellbeing, which comprises the integrity of the human structure. Miligi et al. (2019) advanced the metaparadigm to explore four basic concepts for nurses: mind and body of the patients, the patient as a whole, the patient's health and wellbeing, and the patient's environment.

As discussed in this chapter, hospice and palliative social workers often contend with emotionally and psychologically challenging situations in the workplace (Barnett et al., 2019). Notably, Portoghese et al. (2020) postulated in a recent systematic review that there was comparatively little research for psychological well-being as it related to death and dying for hospice care professionals. Among this group of professionals, which includes hospice social workers, self-care practices are essential to the prevention of burnout and assurance of high-quality patient care (Kuhn & Flanagan, 2017). Miller (2017) suggested that self-care practices improve when there are safeguards in place, such as financial stability, general health, and licensure status. In contrast to Miller's recommendation, Kuhn and Flanagan (2016) found that understanding the context of self-care practices and perceptions on positive and negative indicators of professional quality of life, including burnout, secondary traumatic stress, and compassion fatigue among hospice social workers.

Several researchers have employed the theory of self-care to study the practice for healthcare and social work professionals. For example, Hayter (2016) combined the theory of self-care with social cognitive theory to examine the self-reported competence of palliative nurses working in acute care settings. The researcher found that palliative care nurses felt capable of providing adequate palliative care to patients (Hayter, 2016). Hotchkiss and Cook-Cottone (2019) used the theory to validate the Mindful Self-Care Scale among hospice professionals. Also, self-care theory has been used to examine the self-care behaviors of dementia caregivers (Waligora et al., 2019) and students of social work (O'Neill et al., 2019).

Researchers suggested that self-care is an intimate process by which factors should be considered, such as individual belief systems, cultural, and societal experiences (Pope et al., 2017). In the context of this study, self-care is considered an empowering mechanism to exert agency over one's overall health and well-being (Pope et al., 2017). Much of the research founded on self-care theory focuses on the self-care needs and behaviors of patients and clients, rather than professionals working in healthcare settings. Accordingly, this study may expand upon self-care theory by examining it in context of social workers employed in hospice settings.

Types of Practices

Several self-care practices can help combat the negative experiences of workers in palliative care settings. For example, compassion fatigue and burnout can be reduced through exercise, medication, rest, and self-reflection (Pelon, 2017; Whitebird et al., 2013). Additionally, prioritizing and maintaining close personal relationships, getting adequate sleep, and taking time for personal enjoyment and recreation are other key self-care practices (Sanchez-Reilly et al., 2013).

Social and emotional support may mitigate some of the stress caused by working in palliative care. As Pelon (2017) explained, hospice social workers typically work in isolation from coworkers, dealing with grieving families and dying patients alone. This isolation may contribute to compassion fatigue (Whitebird et al., 2013). Thus, another strategy for improving the wellbeing of palliative caregivers, such as hospice social workers, may be to connect workers with coworkers and managers, allowing time for them to share with one another and process work-related stress together.

Spiritual or religious practices may also help palliative care workers cope with end-of-life issues and reframe their experiences in a positive manner (Holland & Neimeyer, 2005). Holland and Neimeyer (2005) found that regular spiritual practices could provide a buffer against emotional and cognitive burnout among palliative care workers. Similarly, Fitzgerald (2020) found that participation in spiritual practices helped reduce palliative care workers' compassion fatigue. Spiritual practices are also associated with reduced death anxiety among healthcare providers working with seriously ill patients (Bivens et al., 1995).

Laughter and humor can also be powerful self-care and coping practices for palliative care workers. Although research on humor in palliative care settings is scant, findings from a handful of studies reveal the utility of humor as a self-care practice among palliative care workers. For example, Dean (1998) urged hospice leaders to recognize the value of humor in relieving stress and fostering a sense of connectedness among staff. Claxton-Oldfield and Bhatt (2016) examined the effect of a humor intervention on volunteers working in hospice or other palliative care settings. Study volunteers reported that humor helped them cope with the demands of volunteer work and they believed humor had a place in palliative care. Cain (2012) found that humor helped hospice workers deal with the emotional stress of their work and foster a sense of inner strength. Linge-Dahl et al.'s (2018) systematic review of humor interventions in palliative care revealed that humor had a positive impact not just on caregivers, but also helped patients and family members.

Findings from Nunes et al. (2018) challenged those of researchers (Cain, 2012; Claxton-Oldfield & Bhatt, 2016; Linge-Dahl et al., 2018) who reported on the utility of humor as a coping mechanism. Nunes et al. (2018) studied humor among palliative care nurses and found humor was a strategy used by nurses to address multiple forms of stress; however, humor did not appear to be a sufficient coping mechanism. Even so, the researchers also reported that nurses who experienced higher levels of professional grief overload were more likely to employ humor as an adaptive mechanism (Nunes et al., 2018).

Mindfulness is another self-care strategy that may help palliative care workers. Sanchez-Reilly et al. (2013) described mindfulness as purposeful, present attention that cultivates kind and nonjudgmental attitudes toward one and others. Acceptance and curiosity are tenets of mindfulness (Bishop et al., 2004). Mindfulness can help reduce work-related stress and burnout, depression, and anxiety, while improving self-compassion and spiritual health (Boellinghaus et al., 2012; Duarte & Pinto-Gouveia, 2016).

Among physicians, mindfulness has been associated with reduced burnout, increases in overall wellbeing, and improved interactions with patients (Krasner, 2009). Perez et al. (2015) found that palliative care workers were aware of the benefits of mindfulness practices but needed training to learn mindfulness techniques. A similar deficit in training was reported by Orellana-Rios et al. (2018), who studied the effects of mindfulness training on palliative care workers and found significant reductions in burnout, anxiety, tension, and worry. Participation in the training was also associated with increased feelings of joy, work enjoyment, resilience, and awareness. Orellana-Rios et al.'s (2018) investigation supported the benefit of mindfulness training for palliative care workers.

Finally, exercise is one of the most common self-care practices employed by individuals (Bloomquist et al., 2015). Physical exercise can foster gains in general health, promote positive relationships, and reduce risks for depression (Kuhn & Flanagan, 2017 Further, Weight et al. (2013) revealed that individuals who participated in an exercise program experienced improved quality of life and less burnout.

Appropriateness of the Theory

Self-care theory provides an understanding of the core belief for human interaction. Orem defined self-care as a set of ongoing activities that maintain and promote a healthier way of living. Self-care is an intimate process by which factors should be considered, such as individual belief systems and cultural and societal experiences (Pope et al., 2017). According to Orem (1991), self-care also includes human interaction and an individual's ability to learn and apply the principles related to caring for themselves. In the context of this study, self-care is considered an empowering mechanism to exert agency over one's overall health and well-being (Pope et al., 2017). Self-care theory provides a lens to understand the nature of the study's research problem. Moreover, there is a notable lack of literature regarding lack of self-care in hospice social worker who works with terminally ill individuals who has less than 6 months to live.

Review of the Literature

A review of the related research follows, beginning with discussions of hospice and hospice social workers. Next, risks to hospice workers who work with terminally ill are presented, including burnout, compassion fatigue, death anxiety, vicarious trauma, secondary traumatic stress, and turnover. Self-care practices are also reviewed, including compassion satisfaction, spirituality, humor, mindfulness, and exercise.

Hospice

To understand the nature of the work environment of social workers who are responsible for the terminally ill, a description of hospice environments is warranted. Hospice is a type of palliative care provided to patients with 6 or fewer months to live (Shalev et al., 2018). The aim of palliative care is to address the physical, spiritual, and psychological needs of patients with serious illness to increase their quality of life (Shalev et al., 2018). Hospice is a patient-centered care philosophy aimed at helping individuals with life-limiting illnesses (Wladkowski & Wallace, 2019). Hospice services are covered under Medicaid, Medicare, and most private insurances; these services are provided by interdisciplinary care teams comprised of nurses, physicians, therapists, social workers, and other care professionals (National Hospice and Palliative Care Organization, 2017). In contrast to other types of care, hospice care stretches over every hour of every day (National Hospice and Palliative Care Organization, 2017).

Demands for palliative and hospice care services have increased during the last decade (Portoghese et al., 2020). As the aging population increases, the need for hospice care services will continue to rise (Rine, 2018). According to the National Hospice and Palliative Care Organization (2014), nearly 1.6 million dying individuals receive care through hospice each year, and nearly 1.2 million deaths occur in hospice annually. Compassion and care for dying individuals is the foundation of hospice (Dutton et al., 2014); those who work in hospice care are tasked with reducing patient suffering while increasing their quality of life (Portoghese et al., 2020).

Social workers who primarily assist hospice patients are referred to as hospice or medical social workers (Peterson et al., 2018). Hospice social workers support a growing and important role as advocates for individuals and families. With nearly 600,000 social workers in the United States, these professionals comprise a significant segment of human service workers (Bloomquist et al., 2015). Peterson et al. (2018) indicated that hospice social workers are responsible for providing patients with support and resources to help them recover from medical, emotional, physical, and psychological concerns.

Leung et al. (2020) conveyed that hospice social workers are individuals who provide multidimensional support to individuals living with terminal illnesses. On the other hand, Cerully et al. (2018) shared that this support may include a variety of wellbeing domains, such as physical and emotional health, resources, and social welfare. Wladkowski and Wallace (2019) found that professionals conduct psychological assessments, develop discharge plans, arrange home care services, provide appropriate referrals, offer support to patients and families, and serve as patient advocates.

Hospice workers fulfill many different types of roles. According to Callahan (2015), hospice and palliative care workers draw from research, theories, and practices specific to hospice care. They leverage knowledge and services across multiple disciplines to assist patients. According to Middleton et al. (2020), social workers play a prominent role in advanced care planning. In this role, Stein et al. (2017) conveyed that hospice social workers educate families about advanced care planning options and are responsible to lead and document discussions with patient family members. Blacker et al. (2016) explained how the professional roles and responsibilities of hospice social workers can be challenging, as they are forced to navigate between the concerns and needs of multiple stakeholders. Silverman (2016) described that it can be difficult for hospice social workers to navigate between resource management and tending to the needs of terminally ill patients.

Risks to Hospice Workers

Hospice workers, including social workers, are regularly exposed to death and grieving families. As the professional requirements, emotional burdens, and caseloads of hospice social workers increases, so too do risks for occupational stress (Miller et al., 2017). As Portoghese et al. (2020) explained, palliative care environments expose staff to distressing events, such as death and suffering, on a regular basis. Over time, such exposure can create psychological stress (Antony et al., 2018). Hospice social workers' personal experiences with loss and the depth of relationships with clients often influence their experiences with patients' deaths (Quinn-Lee et al., 2014). These workers must regularly manage their own emotional responses when working with patients and families, which can negatively affect their emotional health (Barnett et al., 2019).

Additionally, the stress experienced by hospice workers can be compounded by rising caseloads and the lack of social support and work-related autonomy (Quinn-Lee et., al. 2014). Although work-related emotional stress often undermines the psychological well-being of hospice care workers (Kamau et al., 2014), relatively little research exists on the psychological and emotional wellbeing of these professionals (Hill et al., 2016). This gap in the extant literature warrants further research because stress, burnout, fatigue, and depression among healthcare workers are associated with increased rates of medical errors and reduced patient care quality (West et al., 2009).

As demands for hospice social workers increase, the roles and responsibilities of the profession have become increasingly complex and arduous (Lynch et al., 2016).

According to Miller et al. (2017), changes in ethical guidelines, practice, resources, politics, and increasing complications in treatments create growing stress and demands for workers in hospice settings. It is not just the psychological and emotional burdens of hospice social work that place professionals at risk for increased stress, burnout, and reduced wellbeing (Miller et al., 2017). The upward mobility of employment, professional inconsistencies, and heavy caseloads also place these professionals at risk. Variations in professional duties and supervision, role ambiguity, low levels of professional support, and poor organizational structures can likewise contribute to the professional stress experienced by healthcare social workers (Miller et al., 2017). It is not just social workers in hospice settings who are at risk for the organizational and emotional stressors of their profession; social workers in other healthcare capacities, such as trauma centers and acute care oncology units, are also at risk (Badger et al., 2008; Pelon, 2017).

Researchers have examined the experiences of hospice social workers in a number of contexts, revealing a multitude of professional challenges faced by these individuals. Such scholars have also highlighted the importance of providing hospice social workers with the support needed to maintain their emotional wellbeing. For example, Washington et al. (2016) studied hospice social workers’ exposure to individuals at elevated risk for suicide, including patients and family caregivers. The researchers found hospice social workers should be better prepared to assist individuals exhibiting warning signs of suicide (Washington et al., 2016). Marmo and Berkman

(2016) posited that when there is supportive hospice management leadership, the environment for hospice social worker(s), it improves and or produces a better work environment. McAteer and Wellbery (2013) argued that hospice and palliative care leaders should provide education and training on suicide-related competencies to better prepare hospice social workers to assist individuals exhibiting warning signs of suicide. Although participants in Washington et al.'s study reported feeling prepared for these encounters, the admission that additional training may be helpful indicated a potential gap in professional support and resources provided to hospice social workers. Similar findings regarding the need for more professional training and development have been reported in other studies on hospice social workers. For example, Kovacs and Bronstein's (1999) research on the needs of hospice social workers in oncology settings highlighted the importance of continuing education and field training to help these professionals deal with individuals coping with terminal cancer.

Another area of focus for research on hospice social workers relates to live discharges. As Silverman (2016) explained, social workers are often tasked with Reference administrative pressures. In hospice, live discharge refers to the removal of all hospice-related support while a patient is still alive. Such discharge may occur if a patient is hospitalized, chooses to decline active treatment, relocates, or becomes disqualified for services (i.e., if health is not declining as rapidly as anticipated; Russell et al., 2017). Wladkowski and Wallace (2019) studied how hospice social workers handled live discharges resulting from the loss of eligibility for services. Wladkowski and Wallace

(2019) revealed that hospice social workers often viewed live discharges as a social justice issue. Similarly, Heenan and Birrell (2018) reported that hospice social workers often perceive social injustices with live discharges. Social workers described limited care options available to replicate the support provided by hospice, especially for patients with limited financial resources (Wladkowski & Wallace 2019). Trowbridge and Lawson (2016) explained that hospice social workers face many barriers when there is a need to replicate or supplement unique services upon the individuals' alive discharge. Veerawat et al. (2016) examined the obstacles and challenges those patients, families, physicians, and hospice social workers face when the care is at home versus in a hospital setting.

The term burnout was first coined by Freudenberger (1974) to describe a range of symptoms and emotions, such as irritation, depression, and cynicism, experienced by people in helping professions. Maslach (1978) expanded upon Freudenberg's definition, developing a model of burnout that consisted of emotional exhaustion, depersonalization, and reduced personal accomplishment. Burnout results from exposure to cumulative work-related stress, over time (Stensland & Landsman, 2017). Among palliative care workers, the ethical dilemmas inherent to the profession can contribute to emotional exhaustion and burnout; such dilemmas include patient autonomy when fulfilling advanced directives, withholding treatments, and decisions to not resuscitate (Pereira et al., 2011). Increased end-of-life care demands, and intense clinical stress can increase stress and burnout risks for healthcare professionals working with terminally ill patients (Sanchez-Reilly et al., 2013). Burnout can manifest as cynicism, coldness, and distancing between healthcare workers and patients, creating challenges in palliative care (Pereira et al., 2011).

Individual characteristics, such as female gender, alcohol abuse, a personal history of mental disorders, working in a solo practice, and lack of professional experience can increase workers’ risk for burnout (Kuhn & Flanagan, 2017; Sanchez-Reilly et al., 2013). Work-related factors that can contribute to burnout include heavy workloads, lack of professional autonomy, and a lack of work-life balance (Sanchez-Reilly et al., 2013). Maladaptive coping, compassion fatigue, and older age are associated with increased burnout risks (Slocum-Gori et al., 2013; Stensland & Landsmen, 2017). Some researchers have found work experience to be a buffer against the negative effects of service professions, such as social work (Bloomquist et al., 2015). Although burnout is sometimes used synonymously with other terms, it is distinct from other constructs such as stress, vicarious trauma, and compassion fatigue (Pereira et al., 2011).

Not only can burnout negatively affect professionals’ quality of life but can also undermine their personal health and the quality of care provided to patients (Quinn-Lee et al., 2014). Burnout can affect workers’ self-perceptions, their relationships, and the overall workplace environment (Maslach, 1998). Professional stresses related to end-of-life care can increase burnout risks among palliative care workers. For example, Stensland and Landsman (2017) found that over 40% of hospice workers experienced moderate to high levels of the emotional exhaustion component of burnout. A number of factors can contribute to burnout among hospice social workers, including exposure to excessive loss and difficulty coping with emotional responses to those losses (Slocum-Gori et al., 2013). Other burnout risk factors for hospice social workers include excessive workloads, communication difficulties, and a lack of social support (Quinn-Lee et al., 2014; Slocum-Gori et al., 2013).

Pereira et al. (2011) found that burnout seemed more prevalent among professionals who remained in the same healthcare context for several years, making career length a risk factor; this finding contrasted with Bloomquist et al.'s (2015) report that work experience may protect against the negative effects experiences by those in service professions. Other risk factors for burnout include dealing with death, and increases in professional responsibility, bureaucracy, and team conflict (Pereira et al., 2011). Among nurses in palliative care settings, Ogińska-Bulik and Michalska (2020) found burnout may be caused by traumatic stress. A lack of confidence in communicating bad news (such as patient prognosis) can also contribute to burnout among palliative care workers (Pereira et al., 2011). Among physicians, Zubatsky et al. (2019) found that burnout was associated with increased depersonalization, lower personal accomplishment, turnover, and poorer patient outcomes.

Because many of the risks associated with burnout among palliative care workers can be prevented, training may help prevent burnout among these workers (Pereira et al., 2011; Sanchez-Reilly et al., 2013). In addition to training, a few other practices can help reduce or prevent professional burnout, including belonging to professional organizations, part-time work status, and the use of self-care practices (Stensland &

Landsmen, 2017). Other factors that seem to protect against burnout include spending time with patients and their families, engaging in effective communication, and developing healthy practices to cope with death (Pereira et al., 2011). Organizational support and education on burnout symptoms and risk factors can also protect against burnout (Quinn-Lee et al., 2014).

From an organizational perspective, palliative care workers are more likely to turn over when they do not effectively manage the emotional stress of their work. The financial costs of turnover among palliative care workers are substantial, and high staff turnover can compromise the quality of patient care (Moore & Sheetz, 2014). Burnout, compassion fatigue, death anxiety, and vicarious trauma can all contribute to turnover. Researchers have examined the causes and consequences of turnover among palliative care workers in a variety of settings. For example, Miligi et al. (2019) studied work stress and turnover intentions among a sample of Saudi Arabian palliative care nurses and found that most respondents expressed moderate to high turnover intentions. In addition, turnover intention was significantly and positively correlated with work stress (Miligi et al., 2019). Kim et al.'s (2016) study on geriatric nurses who provided care to terminally ill patients revealed strong correlations between and death anxiety and work-related stress, which can contribute to turnover. Among a sample of doctors, nurses, social workers, and chaplains, O'Mahony et al. (2017) found that personality traits could foster or buffer against burnout. O'Mahony et al. found that individuals who scored high on neuroticism were more likely to experience secondary traumatic stress (STS) and burnout, while those who scored high on agreeableness were more likely to experience compassion satisfaction.

Compassion Fatigue

Compassion fatigue refers to stress resulting from exposure to a traumatized individual. Cocker and Joss (2016) described compassion fatigue as the convergence of STS and cumulative burnout, creating a state of physical and mental exhaustion by reducing individuals' abilities to cope with their everyday environments. Figley (1995) defined compassion fatigue as a deep awareness of others' suffering along with a desire to relieve their suffering. Compassion fatigue has also been defined as tension and preoccupation with the traumatic experiences of others, which can cause individuals to relive traumatic experiences and avoid situations or people that remind them of the trauma (Portoghese et al., 2020). As Barnett et al. (2019) explained, compassion fatigue describes the emotional and physical exhaustion that results from long-term caregiving.

Compassion fatigue develops from empathizing with clients' emotional pain and suffering, and from direct or indirect trauma exposure (Sorenson et al., 2017). Professionals who work in healthcare, emergency, and community service are particularly susceptible to compassion fatigue, which can undermine patient care, relationships with colleagues, and lead to more serious mental health conditions such as posttraumatic stress disorder, anxiety, or depression (Cocker & Joss, 2016). A keen awareness of patient suffering, along with an empathic tendency to bear patients' suffering, can result in compassion fatigue (Figley, 2002).

Ongoing exposure to the suffering of others and concern for them can foster exhaustion on emotional, physical, and spiritual levels (Pelon, 2017). Compassion fatigue is not a pathological process or condition, but a natural response of human caring (Figley, 1995). Compassion fatigue is a common experience among healthcare workers, especially those in palliative care (Barnett et al., 2019). Hospice care workers often bear witness to prolonged patient suffering, with little or no improvement (Mason et al., 2014). While compassion fatigue and burnout are often similarly experienced, they are distinct constructs. Burnout is more likely to be associated with work-related stressors, such as lack of support or high workloads. In contrast, compassion fatigue is the result of an individual's emotional response related to exposure and concern for the suffering and trauma of others (Alkema et al., 2008).

Compassion fatigue can negatively affect care workers in many ways. According to Pelon (2017), compassion fatigue is associated with hopelessness, decreased empathy, disconnection from others, decreased productivity, reduced quality of care provided to patients or clients, job dissatisfaction, apathy, personal health problems, and poor work quality.

Researchers have examined compassion fatigue in hospice settings, but the focus is typically on nurses and doctors. For example, Barnett et al. (2019) examined the relationship between compassion fatigue, emotional labor, and emotional display among hospice nurses. Emotional labor describes the effort put toward controlling or managing personal emotions at work (Portoghese et al., 2020). Expressing positive emotions while suppressing negative ones are viewed as job requirements for individuals providing hospice care (Portoghese et al., 2020). As Barnett et al. (2019) explained, hospice workers must often manage their expression of emotions in order to provide compassionate care, suppressing some emotions and faking others.

Nurses in Barnett et al.'s (2019) study expressed low levels of compassion fatigue. Compassion fatigue was not associated with the expression of genuine positive emotions, but it was associated with the expression of genuine negative emotions Barnett et al., 2019). The researchers posited that this effect may be the result of elevated negative affect among nurses, which then caused them to express more negative feelings (Desivilya & Yagil , 2005). While compassion fatigue was not associated with faking positive emotions, it *was* correlated with faking negative emotions (Barnett et al., 2019). Hospice nurses who faked more negative emotions were more likely to have high levels of compassion fatigue Barnett et al., 2019). That is, compassion fatigue may be the cause of the expression of fake negative emotions rather than the cause.

In a similar investigation, Portoghese et al. (2020) studied the relationship between regular exposure to patient suffering and emotional labor from compassion fatigue. Portoghese et al. found that exposure to patient suffering was positively associated with emotional labor. Burnout moderated this relationship, in that worker who demonstrated more emotional labor were more likely to experience burnout. In another study, Yi et al. (2016) examined compassion fatigue among medical social workers and how it is vital when supporting the health and wellbeing of oncology psychosocial service providers in oncology patients. Yi et al. found that medical social workers employed a number of strategies to combat compassion fatigue, such as communicating with others, setting professional boundaries, and creating grief rituals. Finzi-Dottan and Berckovitch Kormosh (2018) found social workers in public service positions who worked with highly stressed and strained populations were especially vulnerable to burnout.

Death Anxiety

Death anxiety is another challenge that hospice social workers may face. Death anxiety describes concerns about the denial or fear of death, avoidance of death, and reticence to interact with dying individuals (Mallett et al., 1991). Six attributes characterize death anxiety, including emotion, cognition, experience, development, sociocultural background, and motivational sources (Lehto & Stein, 2009).

Researchers have examined the phenomenon of death anxiety among hospice social workers. For example, Quinn-Lee et al. (2014) investigated the relationship between death anxiety and burnout among hospice social workers, discovering a strong relationship between death anxiety and the depersonalization component of burnout. However, the researchers also found that burnout among these professionals were more likely the result of heavy caseloads or challenging cases, rather than death anxiety (Quinn-Lee et al., 2014). Jonasen and O’Beirne (2016) also studied death anxiety among hospice employees, but their focus was not limited to hospice social workers. Jonasen and O’Beirne found that the longer an individual was employed in a hospice setting, the lower their death anxiety scores. Nurses had substantially higher rates of death anxiety than did doctors, which may be due to the greater amount of caregiving time and intensity exercised by nurses (Jonasen & O'Beirne, 2016). Because hospice social workers also spend a great deal of time with dying patients, they may be particularly prone to death anxiety, as well.

Vicarious Trauma and Secondary Traumatic Stress

Other risks faced by hospice and palliative healthcare workers include vicarious trauma and STS. Vicarious trauma is a process in which individuals who work with those who have experienced trauma become so entrenched in helping others that they begin to feel the trauma, themselves (Pereira et al., 2011). STS is an extension of compassion fatigue that can be experienced by those working with or providing support to individuals who have experienced trauma (Bloomquist et al., 2015). According to Ludick and Figley (2017), STS describes negative effects of exposure to indirect trauma, via vicarious trauma. STS is similar to vicarious trauma in that it results from either direct or indirect work with individuals who experience trauma (Ludick & Figley, 2017).

Similar to compassion fatigue, STS also shares features of posttraumatic stress disorder (Figley, 2003) and includes symptoms of avoidance, hyper-arousal, and intrusion (Oginska-Bulik, 2018). Individuals suffering from STS may experience recurring traumatic memories, flashbacks, nightmares, feelings of helplessness, or avoidance of situations associated with traumatic events (Oginska-Bulik, 2018). Victims of STS often include therapists, social workers, doctors, and nurses. STS can undermine occupational function, contributing to reduced job satisfaction and increased professional burnout (Shoji et al., 2014).

The phenomenon of STS among hospice and palliative care workers has been examined. For example, Oginska-Bulik (2018) investigated relationships between resilience, STS, and vicarious posttraumatic growth (VPTG) among palliative care nurses. As conceptualized by the researcher, VPTG described positive changes in psychosocial function experienced by individuals exposed to secondary trauma (Cohen & Collens, 2013). Oginska-Bulik revealed that while participants experienced high levels of STS, nearly 39% of respondents reported positive VPTG, as well. Oginska-Bulik noted that among hospital nurses, levels of STS were higher, while VPTG was lower. In contrast, hospice nurses experienced less STS and more VPTG. Oginska-Bulik also found that respondents' age, education, and employment length were unrelated to STS and VPTG. This finding runs contrary to those from previous researchers who found that the negative effects of palliative care work often decrease with increased professional experience (Bloomquist et al., 2015).

Compassion Satisfaction

Research on the experiences of palliative caregivers is largely focused on the negative effects of stress and compassion fatigue (Pelon, 2017). However, this focus tends to be shortsighted in its lack of acknowledgment of the satisfaction that many palliative caregivers find in their work. As Mills et al. (2018) explained, long-term demonstrations of compassion can also fill workers with a sense of purpose, duty, and fulfillment. The phenomenon of compassion satisfaction describes intrinsic emotional rewards experienced by hospice and palliative care workers who help individuals cope with dying (Hotchkiss, 2018). Compassion satisfaction focuses on the compassionate help, emotional engagement, and worker-client interactions that are gratifying for care workers (Pelon, 2017).

Some of the rewards experienced by palliative care workers include opportunities to work on interdisciplinary teams, find meaning in life, and foster personal growth (Quinn-Lee et al., 2014). Orellano-Rios (2017) reported that frequent exposure to death can help palliative care workers live in the present, find develop a curiosity about life, and cultivate spirituality. A small body of research reveals that while end-of-life caregiving can be exhausting, many workers also find it fulfilling (Radey & Figley, 2007; Slocum-Gori et al., 2013; Stamm, 2002 i). Compassion satisfaction may also provide a buffer against the emotional and psychological stress experienced by hospice workers. Pelon (2017) found compassion satisfaction appeared to create a buffer against compassion fatigue among hospice workers; as compassion satisfaction increased, compassion fatigue decreased.

Research Gap and Conclusion

This comprehensive literature reviewed highlighted multiple gaps that were addressed by this investigation. First, little research exists on the psychological and emotional wellbeing of hospice care workers (see also Hill et al., 2016). Specifically, research on the self-care practices applied by hospice social workers and liaisons is scant

(Miller et al., 2017). Of the research that does exist, most of it is quantitative (Portohese et al., 2020), and few studies focus on social workers and liaisons within palliative and hospice care settings (Stein et al., 2016). For example, Quinn-Lee et al., (2014) found a large body of research on burnout among healthcare professionals, but very little focus on the specific experiences of hospice social workers. Similarly, Mills et al. (2017) pointed out that most of the studies on self-care focus on practices used to cope with burnout and professional stress rather than those employed to promote well-being. Little evidence exists to inform the self-care practices of palliative care workers (Mills et al., 2017).

Self-care practices are essential to fostering resilience and mental health among human service professionals, ensuring long, personally satisfying careers (Kuhn & Flanagan, 2017). Despite the importance of self-care practices for mitigating the stress of working in human service professions such as social work, systematic research on the self-care practices used by these professionals is lacking (Bloomquist et al., 2015). More research on self-care among healthcare workers who contend with emotionally and psychologically draining work environments, such as hospice social workers and liaisons, is needed to develop interventions that may improve workers' wellbeing, reducing staff turnover, and improving the quality of patient care (Kuhn & Flanagan, 2017).

Summary

In this chapter, I reviewed the literature related to my study. I discussed relevant topics and research exemplifying the problem and reiterating the gap in research. In

Chapter 3, I present the specifics on the study design, population, and sample, as well as data collection and analysis plans.

Chapter 3: Research Method

Introduction

Hospice workers often deal with high-stress work environments, which have deleterious effects on concentration, cognition, self-esteem, sleep, and mental health (Castiglione et al., 2016; Eaves, 2018; Galanakis et al., 2016; Kwong, 2016). Hospice social workers and liaisons may experience complex emotions, higher attrition rates, and reduced quality of care for themselves and their patients as a result of the high stress environment. The regular practice of self-care practices may mitigate these negative experiences, helping to improve the retention of hospice workers and the quality of care provided to patients (Xu et al., 2019).

Little research exists on the lived experiences of self-care among hospice social workers and liaisons who work in high-stress environments and provide care to terminally ill patients (Adimando, 2018; Crane & Ward, 2016; Halm, 2017; Kumar & Cavallaro, 2017; Mills & Chapman, 2016). Accordingly, the purpose of this qualitative, descriptive phenomenological study is to understand the lived experiences and self-care practices of hospice social workers and liaisons in these high-stress settings. The study was guided by a single research question: What are the lived experiences and self-care practices of hospice social workers and liaisons who work in high-stress environments and assist with personal care for terminally ill patients?

This chapter contains details of the study's methodology, beginning with a discussion of the design and role of the researcher. The sampling strategy, instrumentation, and practices for recruitment and data collection are provided. Next, the data analysis procedures are described, followed by my plan to ensure the trustworthiness of findings. Finally, ethical assurances are described. The chapter closes with a short summary.

Research Design and Rationale

The method of the study was qualitative, and it followed a descriptive, phenomenological design. The qualitative tradition is appropriate for exploring participants' views of the world, their understandings of their experiences, and the meaning they make from their experiences (Merriam, 2015). As Tracy (2013) explained, qualitative researchers believe that reality is subjective and singular truths do not always exist. In contrast, quantitative researchers believe reality is objective and based on singular truths. Quantitative researchers focus on proving or disproving hypotheses and examining relationships between quantifiable variables (Tracy, 2013). The aim of the proposed study is not to prove an objective reality or test relationships between variables. Rather, I aim to explore individuals' personal, subjective experiences and their interpretations of those experiences. Accordingly, a qualitative method was selected as most aligned with the proposed study.

I chose a phenomenological design for this investigation. Phenomenology is used to focus on participants' interpretations and understandings of their experiences relative to phenomena under investigation (Moustakas, 1994). In addition, phenomenological researchers endeavor to understand participants' experiences within the contexts of their natural environments (Moustakas, 1994). The phenomenon of focus for this study includes the self-care practices of hospice social workers in high-stress environments.

Researchers may choose from a number of phenomenological designs, including transcendental, hermeneutic, and descriptive. Transcendental phenomenology aims at transcending participants' experiences, as this school or research believes that in order to understand realities, individuals' subjective experiences must be transcended (Kafle, 2011). Transcendental phenomenologists believe more objective truths may be uncovered at the base of every phenomenon, (Kafle, 2011). In contrast, hermeneutic phenomenologists focus on individuals' interactions with the world, as those interactions and experiences are used to create meaning and subjective realities (Smith, 2018).

The key to hermeneutic phenomenology is the interpretation of individuals' subjective experiences. This type of phenomenology often focuses on the contexts of social, theoretical, or cultural perspectives (Larkin et al., 2006). Alternately, researchers who practice interpretive phenomenology endeavor to interpret and make sense of the results (Smith et al., 2009), rather than to simply report the experiences as interpreted and described by the participants.

Finally, descriptive phenomenologists aim to explore participants' experiences, reporting the meanings that participants make from those experiences, rather than interpreting them and then reporting them (Padilla-Diaz, 2015). For this study, I selected a descriptive phenomenological design, which draws from the seminal work of Giorgi (2009). Because the aim of the study is not to interpret participants' experiences with self-care practices, but to describe the experiences as they report them, a descriptive approach is well aligned. Previous researchers have employed descriptive phenomenology to understand the phenomena of stress and self-care (Adimando, 2018; Crane & Ward, 2016; Halm, 2017; Kumar & Cavallaro, 2017; Mills & Chapman, 2016).

Role of the Researcher

As the sole investigator of this project, I was responsible for all aspects of participant recruitment, data collection, analysis, and reporting of results. Phenomenological researchers serve as the study instrument, collecting data and allowing it to flow through them (Moustakas, 1994). For this reason, it was essential that I bracket my personal biases, thoughts, and opinions, which I did a through the practice of reflexive journaling. Bracketing is a qualitative research technique to minimize the negative effects of assumptions that could taint the research process. However, due to a shift away from its phenomenological beginnings, the methods by which bracketing occurs are poorly understood (Chan et al., 2013).

For this study, bracketing was used to set aside me personal ideas and opinions throughout the entire processes of data collection and analysis. Bracketing helps ensure study results are based on participants' lived experiences, with minimal intrusion by the researcher (Chan et al., 2013). While I have never worked for either of the participating organizations, I did previously serve as a hospice liaison to both organizations through another company. As a hospice liaison, I communicated with leaders at the two selected organizations to ensure necessary hospice services were available and provided to patients in need. This experience provided me with my existing connections to leaders at both organizations, which I leveraged to obtain organizational consent. There are no conflicts of interest or potential power threats because (a) I have never worked for the participating organizations, and (b) there are no professional conflicts with any of the hospice social workers who participated in this study.

Further, I no longer serve as a liaison to these organizations. I had the opportunity to work intimately with hospice social workers. Although I no longer work as a hospice liaison, I appreciate the importance of doing research, especially engaging customer satisfaction and determining how to leverage this study. As recommended by Moustakas (1994), I bracketed through reflexive journaling to prevent my personal ideas and preconceived notions from influencing the data in any way.

Methodology

This qualitative study followed a descriptive phenomenological design. Data were collected via semi structured interviews with a sample of seven hospice social workers and liaisons. The sampling strategy and sample size are discussed as follows. A description of the interview protocol, which served as the study instrument, is also provided.

Participant Selection Logic and Inclusion Criteria

The population of focus for this study includes U.S. hospice social workers and human service professionals. The sampling strategy employed is both purposive and snowball sampling. Purposive sampling is a non-probability sampling method in which "items picked for the sample are chosen by the researcher's judgment." Researchers frequently feel that by applying sound judgment, they can acquire a representative sample and save time and money (Saunders et al., 2012).

Snowball sampling (e.g., Waters, 2015) was used to identify participants. Using the snowball sampling approach allowed an initial group of participants to identify persons they knew who had different physical abilities using this method. The sample was purposive because only participants who meet the following inclusion criteria were eligible to participate:

- Be a current hospice social worker (long-term care facilities, hospitals, hospice care centers, personal care homes, and in-home care located in North Texas).
- Possess a minimum of a bachelor's degree; and
- Have at least 1 full year of experience as a hospice social worker or human service worker.

The recruitment flyer (see Appendix A) provided details regarding the study's purpose, inclusion criteria, and participation requirements. In addition, the flyer included my contact information, so interested individuals could contact me via email. I emailed potential participants the demographic screening questionnaire (Appendix B) and the consent form (Appendix C). This was to ensure that potential participants are provided the study details and self-identify that they meet the inclusion criteria. Following the interview protocol (Appendix D), I called the eligible individuals who returned the questionnaire and the consent form to address any additional questions and to schedule interviews. Those prospective participants who did not meet the inclusion criteria received an email thanking them for their interest in the study.

Sample Size

In qualitative research, several recommendations for selecting sample size are available. Once saturation is reached, a qualitative sample is large enough, as evidenced by the absence of fresh findings from the data. (Robinson, 2014). For qualitative research, a sample size of eight to 12 people is generally recommended. (Mertens et l., 2017; Morse, 1994; Tracy, 2013). As a result, I aimed to select 12 participants.

To protect the study from natural attrition and sample mortality, I attempted to oversample in the hopes of finding a diverse group of 12 professionals willing and interested in participating in the study, or reaching saturation, which is when no new information is revealed in additional interviews, as recommended by Moustakas (1994). Whereas Colaizzi (1978) recommended roughly 12 people, Sim et al. (2018) recommended at least 10 intervals for phenomenological techniques. If the data obtained from this sample did not approach saturation, I had planned to further recruit participants until data saturation was achieved. I used a final sample size of seven participants.

Instrumentation

Individual, semi structured interviews were used to collect data for the study. The interview protocol (see Appendix E) served as the study instrument. The questions were designed to help me understand how participants used self-care practices. Questions about the issues that hospice social workers and human service professional face, as well as commonly used self-care practices, were based on information gleaned from the literature. To allow for the collection of additional in-depth information, probing and follow-up questions were asked as needed. The duration of the interview was scheduled to be between 30 and 60 minutes. I had also planned to take a 10- to -15-minute break at the end to debrief and answer any remaining questions.

In lieu of a field test, the interview protocol was reviewed by my academic chair and committee. This process helped to establish validity and ensure that the interview protocol was not biased or leading. Once received, the feedback was used to make any necessary adjustments to the protocol. In addition to the interview protocol, a brief demographic questionnaire (Appendix B) was used to gather the basic demographic information needed to describe the sample. Data collected through this questionnaire included information about participant inclusion criteria.

Procedures for Recruitment, Participation, and Data Collection

Prospective participants were recruited from my personal social media (Facebook and LinkedIn), with an emphasis on individuals who resided in the state of Texas area. The flyer contained the purpose of the study, inclusion criteria, and contact information for those who may be interested in participating in the survey. Participants indicated their interest by contacting me via email or phone from the information detailed on the flyer. Once potential participants made contact, I followed up with potential participants by sending them the demographic questionnaire to be completed, along with the consent form. A free or low-cost support resource list was included with this consent form

(Appendix G). In compliance with social distancing guidelines in place for the Covid-19 pandemic, all interviews were conducted via Zoom. After scheduling interviews, I emailed informed consent forms (see Appendix C) to each participant, requesting them to read, and consent by replying to my email with the words “I Consent.” The purpose of the informed consent form was to provide participant autonomy and ensure all participants understand the purpose of the study, participation requirements, risks, benefits, and the study’s voluntary nature. Only those who gave their informed consent were allowed to take part in the study interviews. I kept recruiting until I secured 10 participants.

Following the completion of the recruitment process, research interviews began. For their planned interview, each participant met with me by phone or via Zoom conference. Each participant had the opportunity to ask any lingering questions regarding the study before the interview begins. Once all questions were answered, I alerted the participant that the interview is about to begin, and the recording will start. All interviewees were informed that audio and video recordings for each interview will be retained for transcription and analysis. In addition to recording the meeting via phone or via Zoom conference, I recorded each interview with a digital audio recording device, as a backup recording measure.

To guarantee consistency in data collection, the interview protocol (see Appendix D) was followed for each interview. Probing questions were asked as needed to get more information needed to answer the research question. At the end of each interview, participants were asked if they had any further information about the research topic that they would like to give. I thanked the participant for their time and cease the recording once it’s over. At that point, I went go over the transcript review procedures, which will be occurring after the interviews.

After all of the data had been collected, the data analysis procedure began. To convert audio interviews to textual data, I personally transcribed the interviews. Following transcription, each participant was emailed a copy of their transcript to review for accuracy. The transcript review took place over a 1-week period, during which time participants provided me any necessary revisions to the transcripts. The analytical process commenced after any necessary transcript edits have been made.

Transcript assessment confirmed that (a) transcripts accurately recorded the information participants intended to share and (b) the preliminary analysis accurately reflected the thoughts they wished to transmit. As a result of these methods, any modifications to transcripts or analysis are reported in Chapter 4. The data collecting and transcript evaluation process took about 6 weeks in total.

Data Analysis Plan

For analysis, I employed Colaizzi’s (1978) seven steps for analyzing phenomenological data. In order to improve the trustworthiness of the study and to ensure data are not influenced by my personal thoughts or biases, bracketing was performed using a reflexive journal. The reflexive journal was used to help me become aware of any personal bias or opinions, write them down, and intentionally bracket them away from the study data. The reflexive journal was used any time I interacted with the data. The contents of this journal will remain private, as it is simply a tool to help ensure the integrity of study data.

Colaizzi’s (1978) method consists of seven distinct steps and depends on rich, descriptive data obtained from sources such as interviews. The first step is familiarization, in which the researcher reads through the data several times. In the case of the proposed study, the data will consist of interview transcripts. This process helped me become well acquainted with the data and begin to notice patterns within it. The second step of the Colaizzi method is identifying significant statements. For this step, the researcher examines all statements made by participants, which are directly aligned with the study phenomenon. After identifying statements of significance, the researcher moves to Step 3, which is to formulate meanings. During this step, the researcher uses statements of significance to formulate meaning, choosing which statements are most relevant to the study phenomenon. In Step 4, the themes are developed from the statements that emerged in the previous steps. For Step 5 of the Colaizzi method, information from the previous steps is used to develop a comprehensive description of the study phenomenon. This description must include all themes developed during Step 4. For the 6th step, the comprehensive description developed in Step 5 is condensed down to a short statement that captures the core phenomenon; that is, just the essential. The final step, seven, involves returning the statement from Step 6 to all participants to ask them whether it captured the ideas, experiences, and sentiments they intended to convey.

Each participant received an email with a summary of this early analysis to ensure that their opinions had been accurately represented. Participants were urged to send any changes or additions to me via email. The member verification procedure resulted in any adjustments to the analysis, which are described further in Chapter 4. The final phase in the analysis was to write a narrative of the findings. The themes and subthemes, in detail, with examples and direct quotes from participant interviews to back them up will be presented in Chapter 4.

Issues of Trustworthiness

I employed several steps to help ensure the trustworthiness of the study data. According to Connelly (2016), trustworthiness describes how closely the findings from a qualitative investigation reflect the truth of the topic or phenomenon under investigation. The four types of assurances for trustworthiness include dependability, confirmability, credibility, and transferability (Kyngäs et al., 2020).

Dependability

The dependability of findings, which refers to how stable they remain over time (Anney, 2014), was established through the audit trail, transcript review, and member checking. Although the goal of qualitative research is not to produce generalizable results, the final check of trustworthiness is how well results transfer to different contexts (Merriam, 2009). Using data from interviews and demographic questionnaires, I developed rich descriptions of the sample and findings, which may improve the transferability of my findings. Because of the small sample size, findings will not be transferable to other populations or contexts.

Confirmability

Korstjens0 and Moser (2018) described confirmability as the degree to which findings from an investigation can be corroborated by other researchers. Researchers can improve the confirmability of a study by keeping an audit trail of all study data and procedures, so an investigation may be replicated by other scholars. Accordingly, I kept a detailed record of all study procedures throughout the entire research process.

Credibility

The credibility of an investigation describes how accurately the researcher captured the ideas and sentiments expressed by participants (Cope, 2014). According to Thomas (2016), member checking is an effective way to increase the credibility of a study because it allows participants, themselves, to review and confirm the accuracy of an analysis. I employed transcript review to establish the credibility of my results.

Transferability

According to Slevin and Sines (2013), the second technique is to incorporate specific defined criteria within a study to increase the truthfulness, consistency, and transferability of qualitative research. It gives an overview of the study and improves qualitative research in terms of veracity, consistency, and transferability.

Ethical Procedures

A number of steps were employed to ensure the protection and ethical treatment of all individuals who participate in this study. The first ethical assurance occurred through approval from Walden University's Institutional Review Board (IRB). 03-04-22-0746202 participants were recruited or interviewed until IRB approval has been granted.

The identities of all participants and the two participating organizations will be protected via pseudonyms. In addition, no information that could be used to identify the organizations or participants were included in the results. No questions that could place participants in compromising positions with their organizations were asked, as it is possible that organizational leaders may find out which hospice social workers from their facilities participated in this study. The autonomy of participants was ensured via informed consent form, which helped ensure that they understand the purpose of the study, participation requirements, risks, benefits, and the study's voluntary nature. (see Bankert et al., 2020).

All participants had the right to withdraw from the study at any point, and for any reason. In addition, participants were able to skip any interview questions they did not wish to answer. Because care was taken to protect the identities of all participants, there were no significant risks to participation, other than any normal discomfort an individual may experience while sitting or standing to participate in the online interview. No incentives were offered, and participants may experience no direct benefits through participation.

Study data will be protected for a period of 5 years. I am the only person who will have access to study data, which will be stored on my personal computer, in an encrypted, password-protected file. For this study, all data were digital. A key linking the names of participants to their pseudonyms was not retained. All study-related data will be securely stored, either in a locked cabinet or password-protected computer, for a period of 5 years after study completion, and then it will be permanently deleted.

Summary

The purpose of this descriptive phenomenological study was to understand the lived experiences and self-care practices of hospice social workers and liaisons in high-stress settings. The study was guided by a single research question: What are the lived experiences and self-care practices of hospice social workers and liaisons who work in high-stress environments and assist with personal care for terminally ill patients? Data were collected via semi structured interviews hospice social workers and liaisons working in two long-term care facilities. Interview data were analyzed using Colizzi's (1978) seven steps for analyzing phenomenological data. Findings will be thematically organized and presented in the following chapter.

Chapter 4: Research Findings

The purpose of this phenomenological study was to explore the lived experiences of hospice social workers and other human service providers. As life expectancies increase alongside the rise in chronic, life-limiting conditions, demands for hospice workers have soared (Kamal et al., 2020). Because of the nature of hospice work, high rates of burnout (Cetrano et al., 2017), death anxiety (Quinn-Lee et al., 2014), compassion fatigue (Cetrano et al., 2017), and vicarious trauma are common among hospice workers (Pelon, 2017). Although research exists regarding the self-care of doctors, nurses, and other healthcare professionals (Mills et al., 2018), little is known about the lived self-care experience among hospice social workers and liaisons. Thus, this study sought to understand the lived experiences of hospice social workers and liaisons who work in high-stress environments and provide care to patients who have been given a prognosis of 6 months or less to live (Adimando, 2018; Crane & Ward, 2016; Halm, 2017; Kumar & Cavallaro, 2017; Mills & Chapman, 2016).

This inquiry was motivated by the self-care that clinicians exercise. Stress, burnout, weariness, and depression among healthcare workers are linked to increased medical errors and poor quality of patient care. Ongoing conversations about this and a review of recent literature helped reveal a gap in the knowledge that required additional investigation (West et al., 2009). Chapter 4 contains the research setting**.** This section also describes the participants' demographics, the data collection process, the data analysis, the study results, evidence of study trustworthiness, and the summary.

Research Setting

All interviews were performed online through Zoom among hospice social workers living in Texas. I emailed the informed consent forms to each participant after scheduling interviews, asking them to read, sign, and return them ahead of time. Only those who gave their informed consent took part in the study interviews. I interviewed seven participants.

Demographics

This study used purposive and snowball sampling techniques to compile a sample of six social workers (SW) and one human services professional (HSP) in Texas. The study's participants either managed or worked as social workers and other human service professionals. Demographic information is shown in Table 1 below. Each participant identified as a Black/African American or Caucasian woman with 3-40 years of experience as a social worker or Human service professional working extensively in hospice. The social workers/HSP ranged in age from 35 to 62 years old. In this phenomenological investigation, the perspectives, and unique experiences of seven social workers and one HSP in Texas were the main subjects. SW/HSP, who assist patients with less than six months to live, served as the study's sample.

Table 1

Participants' Demographics

Participants	Ethnicity/race and gender	Years working in hospice	Degree type/concentration
P1	African American/Female	3	Ph.D.
P2	African American/Female	5	BS
P3	Caucasian/Female	20	MS
P4	Caucasian/Female	4.5	MS
P5	African American/Female	40	MS
P6	Hispanic/Female	13	MS
P7	African American/Female	17	AS/Certificate

1. Participant 1 (P1) had three years of experience as a nonprofit leader. P1 is a License Clinical Social Worker with two more years of clinical supervision under a board supervisor and practicing exam.
2. Participant 2 (P2) had experience working with children with substantial mental health problems and special needs in the child protective services division. She had worked with sex offenders and children with trauma. After attaining her degree, she worked with adults with mental health issues for approximately 5 years.
3. Participant 3 (P3) had over 20 years of hospice care experience. She began as an intern and found she enjoyed it, deciding it was the field where she wanted to work.
4. Participant 4 (P4) had 4 1/2 years working for a small hospice. Having worked for many years with big corporations, she preferred working with smaller companies.

5. Participant 5 (P5) had almost 40 years of experience in hospice social work. While providing hospice care, she earned her LCSW. During the study, P5 worked part-time mentoring incoming social workers.
6. Participant 6 (P6) had 13 years in the human services industry. P6 was a master level hospice social worker who typically took the lead.
7. Participant 7 (P7) had spent 17 years working in human services for psych and human services, mostly with hospice patients.

Data Collection

After receiving IRB approval, I proceeded with participant selection and data collection. I posted the study invitation (research flyer) on my social media platforms – LinkedIn, Facebook, and Instagram – and requested that it be distributed to hospice social workers currently employed by anyone in the capacity of hospice clinicians. The study invitation (see Appendix B) provided details regarding the study's purpose, inclusion criteria, and participation requirements. I asked interested individuals to contact me via phone or email to schedule interviews. I conducted the interviews via Zoom between May and August 2022. Interviews lasted approximately 30 minutes. After each interview, I listened to the recordings and began the transcription process. I transcribed the audio data after each interview. I also shared a copy of the transcribed recording with the participants to confirm accuracy.

Data Analysis

I used Colizzi's (1978) thematic analysis procedure, which is widely used for qualitative research, for analyzing phenomenological data for this study Specifically, I followed an inductive procedure led by the data. The participants' descriptive thoughts and experiences were identified through coding. I did not predefine the groups. I employed NVivo qualitative analysis software to aid in data analysis. I followed Colaizzi's seven-step method to identify key statements, guiding me in developing the codes and themes.

Step 1: Reading the Transcripts

After listening to the seven audio files, I transcribed and converted them to MS Word documents. I reviewed the transcriptions several times and listened to the interviews to familiarize myself with the content, depending on the interview notes to better my understanding of the transcription content. Additionally, I employed bracketing to prevent and check bias, presumptions, and prior conceptions about guiding hospice social workers and human service professionals before and during data collection and analysis. I noted any words, phrases, sentences, or paragraphs that stuck out or were repeated frequently during this stage.

Step 2: Significant Statements

I made further comparisons by reading through the words, phrases, sentences, or paragraphs in this step. This time, the objective was to establish significant statements applicable to the study issues. I also delineated phrases, sentences, paragraphs, words, or sentences irrelevant to the study topics. This is an important step in qualitative research, including thematic analysis, as it helps to improve the quality of the research by allowing researchers to focus on the most important data and ensure that their findings are based on rigorous analysis (Braun & Clarke, 2022). I read through the highlighted words, phrases, sentences, or paragraphs I had highlighted once more with the objective to re-establish a clear relationship or relevance to the study issues.

Step 3: Formulated Meanings

In this step, I allocated units of meaning to the codes identified in Step 2. From the identified textural data, I drafted meanings and summaries to describe the significant statements. Table 2 lists the codes I generated, and Table 3 outlines the units of meanings I allocated to the significant statements anchored on the codes.

Table 2

Initial Codes (Basic Units of Meaning)

Initial codes in descending order	*n* of participants contributing (N=7)	*n* data references
Self-care involves maintaining boundaries or balance	6	13
Cultivating self-care by getting support and working with the team	6	7
Good employers take care of their employees which boosts self-care	5	7
Self-reflection and engaging in activities of personal interest	5	9
Work can be overwhelming causing burnout	5	10
Practicing selfcare by finding and creating time to recharge	4	5
Patients' anxiety in light of imminent death	4	4
The nature of work is hard and stressful	3	5
Some patients do not always feel death anxiety	2	2
Practicing self-care by not answering work phone calls after work hours	2	5
Spending time with family and loved ones	2	2
Some companies' management and work environment are unconducive	2	3
Hospice workers advocate for themselves and fight to get the necessary resources	2	2
In hospice work, workers need space to vent	2	3
Compassion anxiety caused vicarious trauma	2	3
Healthy lifestyle	2	3
Participant understanding of self-care	1	1
Constant discussion about death	1	1
It's challenging providing help to children and criminals with mental health needs.	1	1
Terminally ill patients can be suicidal	1	1
Compassionately treating patients as would want to be treated	1	1

Step 3: Categories

I reduced the significant coded statements by grouping them into categories. Each category was a summary of phrases, sentences, paragraphs, or words determined to be pertinent to or associated with the category. During this stage, patterns from the grouped coded data sets appeared. Through further analysis, I compared emergent trends. In this instance, participant quotes from the data were retrieved to support the pattern after a continual comparison was conducted to identify the data that matched a particular pattern and pair it with the matching pattern.

Table 3

Categories Development

Developed Categories	Unit of Meaning from the Codes
Nature of work	Overwhelming work burnout, the nature of work is hard and stressful
Work environment	Workers need space to vent, workers advocate for their rights and fight to get the necessary resources
Threats to self-care	Patients' anxiety in light of imminent death, Constant exposure to discussion about death, challenging of providing help to children and criminals with mental health needs.
Self-care practices	Maintaining boundaries or balance, engaging in activities of personal interest, not answering work phone calls after work hours, finding and creating time to recharge, healthy lifestyle, participant understanding of self-care, compassionately treating patients as would want to be treated
Compassion anxiety	Compassion anxiety, vicarious trauma
Death anxiety	Some patients do not always feel death anxiety, terminally ill patients, suicidal patients
Social groups support	Cultivating self-care by getting support, working with teams, family and loved one's support.
Workplace management	Good employers mind their employees, poor company management and unconducive work environment

Step 4: Exhaustive Description of the Phenomenon

I put together and grouped into basic themes the categories with related meanings. Each theme was comprised of how similar the supporting significant messages were. This refinement enabled internal homogeneity and external heterogeneity.

Table 4

Themes that Emerged Exhaustively Describing the Phenomenon

Developed Categories	Themes
Nature of work	Hospice work was overwhelming, stressful, caused burnout and some workplaces lacked necessary resources.
Work environment	
Workplace management	
Self-care practices	Hospice social workers practiced self-care strategies by maintaining boundaries from work, doing activities of personal interest, creating time to recharge, leaned on support groups and lived a healthy lifestyle.
Social groups support	
Compassion anxiety	Hospice social workers encountered compassion anxiety, and vicarious trauma from interacting with terminally ill and suicidal patients.
Death anxiety	
Threats to self-care	

Three themes that emerged were a) hospice work was overwhelming, stressful, caused burnout and some workplaces lacked necessary resources; b) hospice social workers practiced self-care strategies by maintaining boundaries from work, doing activities of personal interest, creating time to recharge, leaned on support groups and lived a healthy lifestyle; and c) hospice social workers encountered compassion anxiety, and vicarious trauma from interacting with terminally ill and suicidal. I exhaustively explained and expounded on the themes concerning the lived experiences and self-care practices of hospice social workers and liaisons who work in high-stress environments assisting terminally ill patients. In the report, I explained the ideas and illustrated participant experiences using quotes from the respondents (Colaizzi, 1978).

Step 6: Fundamental structure

In Step 6, I refined the themes based on participant quotes.

Step 7: Validation of Exhaustive Description and its Fundamental Structure

In Step 7, I emailed the transcripts to the participants, requesting them to confirm the transcription and the significant statements they mentioned in the interview were accurately reflected. I requested each participant send an email response within 7 days if they wanted any changes made. I did not receive any revision requests. I continued with the transcription as a result, giving each participant's statements their full actualization. The statements were not altered or biased in any way.

Evidence of Trustworthiness

I employed several steps to help ensure the trustworthiness of the study data. According to Connelly (2016), trustworthiness describes how closely the findings from a qualitative investigation reflect the truth of the topic or phenomenon under investigation. I adhered to the four assurances commonly used to enhance trustworthiness in qualitative studies. These are dependability, confirmability, credibility, and transferability (Kyngäs et al., 2020).

Dependability

The dependability of findings refers to how stable they remain over time (Anney, 2014). I ensured dependability by detailing the study design, rationale, and chosen methodology. I used the same interview questions with all the participants. To increase the dependability of the results, I included related quotations or significant messages from different participants to support a study finding or conclusion.

Confirmability

Korstjens and Moser (2018) described confirmability as the extent to which other researchers can confirm findings from an investigation. To ensure confirmability with the present study, I kept an audit trail of all study data and procedures, and I wrote memos during the interviews and data collection and analysis phases. In the study reports, I used direct quotes from the participants to maintain the originality of the interviewee's perspective.

Credibility

The credibility of an investigation describes how accurately the researcher captured the ideas and sentiments expressed by participants (Cope, 2014). It's the confidence with which others can view the study (Korstjens & Moser, 2017). To ensure credibility, I followed Thomas' (2016) member-checking recommendation, which is an effective way to increase the credibility of a study. I used predefined selection criteria to screen all participants. The participants were asked to review and confirm the transcriptions' accuracy and the study report's correctness once. Further, participant responses were reported verbatim.

Transferability

Transferability is the extent to which findings can be applied to similar but different study settings (Korstjens & Moser, 2017). I ensured transferability by detailing the study settings, site selection strategy, research context, and description of participants, providing thick descriptions of participant stories and all the procedures I followed in the entire study.

Results

This study focused on the lived experiences and self-care practices of hospice social workers and liaisons who work in high-stress environments and assist with personal care for terminally ill patients. The findings of the analysis and the themes that emerged are presented in this section. The scope and complexity of the materials provided by the research participants were determined by the individual's contributions to the study (Williams & Moser, 2019). Based on the recognized patterns found in the examined data, themes were generated. After the analysis, three themes emerged.

The single research question was as follows: what are the lived experiences and self-care practices of hospice social workers and liaisons who work in high-stress environments and who assist with personal care for terminally ill patients? The experiences varied depending on the type of social care work an individual undertook. Similarly, participants reported adapting different self-care practices to navigate the high-stress environment of hospice social work. The three themes that emerged consistent with the single research question are:

1. Hospice work was overwhelming, stressful, caused burnout and some workplaces lacked necessary resources.
2. Hospice social workers practiced self-care strategies by maintaining boundaries from work, did activities of personal interest, created time to recharge, leaned on support groups and lived a healthy lifestyle.
3. Hospice social workers encountered compassion anxiety and vicarious trauma from interacting with terminally ill and suicidal patients.

Theme 1: Hospice work was overwhelming, stressful, caused burnout and some workplaces lacked necessary resources.

Participants described the nature of work and the working environment when working with terminally ill patients. They expressed the work as hard and stressful, which threatened self-care. Also, they noted that work could be overwhelming, leading to burnout. Participants mentioned they advocated for their rights and fought to get the necessary resources to navigate the demands of excess work- and job-related stress. Amongst themselves, they created spaces to vent. Further, they noted that when employers created conducive work environments, positive conditions enhanced employee’s self-care.

To confirm that hospice work is hard, Participant 3 expressed that work was more challenging because, as a social worker, the participant saw patients and dealt with other duties like supervising nurses and handling marketeers.

> I would get think, it is, really doing hospice social worker is really hard job and a lot of people going into it don't realize. You're also a part time therapist for your other staff members. Ok. They think well I only see clients. I only see patients 25 hours a week. The rest of the times churning. No. You got probably 10 hours in there of dealing with nurses and marketers and aides that are upset that need help.

Participant 7, who at the time of the study was a case manager but had extensive experience as a hospice worker, affirmed the sentiments of Participants 3, noting that work was challenging and stressful. "I truly enjoyed working with hospice patients, but it was a bit challenging […] Preparing the family for life transition about loss of life for a love was stressful but it was my responsibility to create a smooth process."

Participant 2 suggested that fellow employees start a team building and socialization session to help hospice social workers deal with the pressure of the workload. "[…] a lot of people are in the field meet people; you know just digress from the workload. But yes, I did, offer that [team building sessions] idea […] My job is stressful. <Laugh> you [the interviewer] ask questions that I was happy to vent on, honestly."

Participant 2 further expressed sometimes feeling overwhelmed and lamented dealing with tasks they could not solve after being allocated client duties unrelated to their docket and work.

> So sometimes I get overwhelmed with things that I cannot solve and clients that really aren't mine […] And then wondering when they are being completed,

> because you don’t have the capacity to do that right. When you’re contracted and you on their certain county or state literature is only so much that somebody can do. You know. And so, we, we find ourselves, a lot of the time picking up slack for other entities when we can’t do that […] many hours I wouldn’t do it because it’s too exhausting especially when you can’t get your work done.

Participant 7 recalled being overwhelmed with a situation that led to neglect of self-care. “My schedule is very busy, so it’s not a lot of time for self-care for me until I lost my best friend and my grandmother soon after.”

Participant 6, a 62-year-old adult, noted that even though current work required working one or two days a week, each day required putting in long hours, noting that, if as a social worker, the participant was required to work the same number of hours fulltime, they would not do it because was exhausting.

> I’m only working one day a week, one to two right now. They are long days and that’s the way it is right now but if I had a job full time job then I had to work this many hours I wouldn’t do it because it’s too exhausting especially when you can’t get your work done.

The participants also noted the role of the managers or leaders in enhancing or hindering social workers’ self-care efforts. The impact was either caused by the leadership style or the work environment the leaders cultivated. Participant 2 noted that the manager allowed her to have flexible or shorter working hours once a day a week.

> Well, my boss allows me to work from home half a day, once a week. And so that's big for me because like I'm really kind of like her right hand at the office […] And so she does allow me to work from home once a week. So that's really helpful. And that helps, a lot. And you know, I, I really can leave when I'm ready, you know, if that makes sense […] once I'm done with my day and I've reached, you know, capacity.

Participant 4 noted that the hospice owner where she worked was very supportive and appreciated her work, which helped her remain focused. The company continued paying her allowances after her cancer diagnosis and she had to take regular medical leaves. These gestures helped build her self-care efforts.

> I have worked at one small company for four and a half year over 4 1/2 years now and. That's my favorite place to be. We built a good team, and my supervisor really recognizes my knowledge and my expertise. They really give me the room to maintain my own sanity and […] then right after that I was diagnosed with breast cancer, and I needed to be out for surgery. And my boss, my boss is the owner, right? My state. It's a small company, its family owned. Well, they gave me a paycheck. You know, just one during that time off, but they gave me a paycheck, cause, they were like, you're not working, but we still value you, and I would end even though I wasn't working. I showed up for a couple of meetings. That I could come to and try to participate and keep up but they kind of let me run

> with things and if I need time off, they're really good. Ok. You've got that time off.

Participant 7 also echoed the impact of a good manager in reducing work stress and leadership efforts that enhance self-care. The participant noted the manager cared about her hospice support staff, the patients, and their families. She rewarded them well and even worked alongside the workers when the workload was excessive.

> The manager was thoughtful, and she was the greatest director that I ever worked with. She cared about her workers and the patients and family. She would get in there herself and work right alongside of workers when we had deadlines or issues. She just didn't do all his work. She cared about her employees. She was always rewarding, giving you encouraging words. I worked with a great team.

On the other hand, bad hospice leadership threatened self-care, the patients, and their families, as Participant 4 narrated about a company she previously worked with.

> I did work at a company that was, horrible and […] I've never understood how a company that worked with death and dying, not recognize that people have issues and complications and illnesses, and I just didn't get it. They were horrible.

Participant 5 also recalled working with an awful manager who was unsupportive and poor in communication. "I did have an awful manager who lacked support and was poor with communication. The manager that was awful was a nurse and […] she was really bad. Oh boy! Hey, it's either really good [managers] or really bad."

A survival tactic to deal with work environment stress was venting. Participant 2 discussed looking for a safe space to vent to other staff. Participant 2 said, “Once I’m done with my day and I’ve reached, you know, capacity, we staff, you know, I can vent, you know, it’s really a safe space.”

Participant 3 narrated that meetings with colleagues at the doctor’s plaza provided space for venting. During the venting sessions, she expressed her feelings to close colleagues and shared her personal plans. Participant 3 said

> [At] doctor plaza self-care that you will hear Hospice social workers talk about a lot where can simply vent about how I am feeling personally […] I have a couple of other hospital employees that I’m able to kind of vent too. They work for the same company as me so I can talk about plans with them a little more personal. I find that helps because I can call my friend girl and say did you see that? What was it about?

Participants fought and advocated for themselves to enhance their self-care at work, as Participant 4 noted.

> I’ll fight tooth and nail and advocate for anybody on our team to make sure that we’re recognized, we’re supported, we’re given what we’re needed. That’s awesome light for it. Not the social workers like they can do that, but they really should because that’s their job. For others, and we need to advocate for ourselves.

Participant 1 also echoed Participant 4. The participant noted she had to advocate for herself when allocated excess work.

> Another part of that is advocate, advocating for yourself as a social worker advocate for yourself you know. Hey, you know I got 40 pages on caseload you know you got me to look into hiring another social worker […] I'm going to need some help or you know. Because you have to take care and it starts with self.

Theme one largely captured the lived experiences of social workers and liaisons who work in high-stress environments assisting terminally ill patients. In this theme, the participants described the nature of work and the working environment. Based on participant expressions, hospice social work was deemed hard, stressful, and threatened self-care. Hospice social work was judged as overwhelming and caused burnout.

To survive the stressful nature of hospice work, it was critical for hospice workers' rights to be respected and workers to be provided with the necessary resources to navigate the demands of excess work and job-related stress. Consequently, employers who created conducive work environments and nurtured positive conditions enhanced hospice employees' self-care. It was also evident that venting to colleagues helped hospice workers to deal with the jo-related stress.

Theme 2: Hospice social workers practiced self-care strategies by maintaining boundaries from work, doing activities of personal interest, creating time to recharge, leaned on support groups and lived a healthy lifestyle.

In this theme, participants described the self-care strategies they use to mitigate the effects of the hard and stressful work and the sometimes-unconducive working environment when working with terminally ill patients. Two key tactics emerged, which were self-care practices and utilizing group support. Self-care practices are the individual initiatives the hospice workers mentioned they use to enhance self-care. The participants mentioned maintaining boundaries or balance between work and personal life, engaging in activities of personal interest, not answering work phone calls after work hours, finding and creating time to recharge, leading a healthy lifestyle, and consciously understanding self-care. Participant 5 put it precisely that self-care was about creating boundaries and learning to decline things. "[In] self-care, you must set boundaries and learn to say no […] assisting others but letting them know it is ok to say no and create boundaries."

For Participant 2, setting boundaries was about appreciating human limits after putting our best effort at work:

> […] reminding myself that, you know, you can only do so much, you're doing what you can and just try to present the best results, you know, don't beat yourself up because it's not perfect […] Self-care it's very important that you set boundaries and not just once, you say no.

In addition to setting boundaries, the participants mentioned engaging in self-reflection and undertaking activities of interest unrelated to work to enhance self-care. Participant 2 pursued coaching, reading, and creating self-reflection moments.

> [I] take some time to do things I like to do. Use my own coaching skills, and that way I'm fresh when I get back to it [work]. It would be reading, and I like to have moments of solitude. So, me just being by myself, it could be at the beach. It

> could just be alone with myself, just listening to my thoughts and just coming over with a master plan, even if it's a minute one.

Participant 5 took breaks from work and went on vacations. "[…] you have to not get a point to take care of yourself. Right. You have to take breaks and vacations to provide extra time for yourself."

Participant 3, like Participant 5, also talked about taking vacations. She mentions doing some self-care activities once a month. In addition to vacations, she mentioned reading as another of the self-care practices that help her avoid burnout.

> [I] do things daily and once a month that provide self-care such allowing myself not to focus on my patients. Or simply read a novel that is not related to patient care. […] I also take vacation days to prevent additional burnout.

Another self-care practices the hospice workers mentioned was practicing not answering phone calls after work hours. This behavior resonates with creating boundaries. Participant 3 mentioned that she had to find a work-life balance. "Finding balance in my life that I can put the phone away and turn off […] I would turn off my work cell phone so that I can care for myself properly."

Participant 4 has a hard rule about work phone calls after 5:30 PM. She does not answer them.

> I don't answer the phone after 5:30 unless it's an emergency. I really don't even if it's a colleague. if it, if there [is an emergency] I know. You know, they'll call me

> twice in a row if it’s an emergency and they know that, and I’ll answer this second time.

Due to the exhausting nature of social work, participants mentioned creating time to self-recharge as another self-care activity. For participant 3, recharging was sitting in the car, drinking tea or ice water, or visiting the bathrooms to unwind between patient sessions.

“I always have either tea or ice water in my car so I can stay hydrated that’s kind of - myself care that I do for myself during the day […] I know where all the clean bathrooms are so I can simply unwind between patients.”

For participant 7, recharging to enhance self-care was as simple as walking inside the house: “But I’ve been trying to take self-care and just move around a little in the house and try to get my energy level going.”

Participant 2 recharges by meditating. “For me is just basically recharging, remembering, you know, first, appreciating life, my life and where I am and just, you know, being thankful for, you know, able to make decisions and choices and free will.”

Ensuring a healthy lifestyle was also mentioned as self-care practice. Participant 5 said the following about self-care. “Personally, I try exercising proper diet […] focusing on my personal health. Participant 7 noted maintaining a healthy diet at home and work in line with healthy living.

> […] keeping the healthy food at the top at work is, in my work area now is kind of hard. But, I, what I’ve tried to do is implement a healthy snack in between

> meals to some days it's just breakfast and not able to get another mealtime to get out which is not a good thing. So, it is important for me to try and stay healthy. I walk a lot at work. It's just a day-by-day process.

In addition to individual self-care strategies, the participants mentioned leaning on the support of social groups to enhance their self-care efforts. Participant 1 noted that when she was still new in hospice social work, her self-care helps largely came from other social workers. "A lot of my support came from other social workers who were already in the field, who already working, you know. cause when I started working in Hospice I was in clinical supervision."

Participant 7 noted that the social group at her workplace was not just for socialization. It was very supportive when she was diagnosed with diabetes.

> At work, we helped one another stay focus on self-care, we took care of each other - we walked, and talked about our personal thoughts. It was a track outside the building. So, we all went out there and took breaks and walks, just to be encouraging. And when I was diagnosed with diabetes, they were like, "I put that down on, you can't have that." So, once again, that was a great team to work with where we all supported each other and if we knew that, you know, something was going on personally. We were able to um. Stepping in and being confident without interfering with each other's business. However, you can notice a difference. Awesome. That is fantastic.

Theme two summarized the self-care strategies of social workers and liaisons who work in high-stress environments assisting terminally ill patients. Self-care practices were personal initiatives the hospice workers employed to enhance self-care. Self-care practices and group support helped the hospice workers cope with the stressfulness of their work. Participants ensured self-care by maintaining boundaries, balancing work and personal life, and engaging in activities of personal interest. Self-care was also ensured by not answering work phone calls after work hours, finding and creating time to recharge, leading a healthy lifestyle, and consciously pursuing self-care activities.

Theme 3: Hospice social workers encountered compassion anxiety, and vicarious trauma from interacting with terminally ill and suicidal patients.

Participants described their lived experiences working with terminally ill patients in this theme. The participants expressed encountering compassion and death anxiety due to interacting with patients anxious about imminent death, constant exposure to the discussion about death, or because of observing the challenges of providing help to affected children suffering from mental health illnesses. Participant 7 recalled her compassion and death fears in her early days. She dug into her spirituality to overcome her anxieties. “When I began to work with hospice, being saved [spiritually saved] helped a lot. Also, because I had a fear myself of death and dying at first. Initially I thought wow, I got to hear about the death, and I had to help families, but worked it out smoothly for me.”

Participant 1 noted that helping others deal with their issues led to burnout and drained energy threatening a social worker's ability to offer services.

> In general, we encounter other people's problems, and it can become burdensome so much so that we experience what's called burnout or even compassion fatigue you know. Basically, caring so much that you just tired so don't care just taking care of yourself so that you're able to take care of others whether it's your family or in this case your patient or your client that you deal with every day you know. As the old adage says you know you can never pour from them in big line so how can you be effective when you have no time, energy or effort to give so that starts with self-care.

Participant 2 noted that in some cases, she had to deal with and constantly watched terminally ill patients who were suicidal.

"So, I've had to help arrange like long term care, mental health care weekly you know risk of harm plan to assure, you know, cause at this time a lot of people might be suicidal. So, we, had to, you know, make sure he had that weekly contact."

In contrast to encountering death anxiety, in some cases, the participants reported dealing with patients who had come to terms with the idea of imminent death. These patients did not display death anxiety signs, as Participant 4 recollected.

> Oh well, yeah, just anxiety. It depends. - I have some clients who, they don't have a lot of anxiety with it [death] because they have led full lives. They feel at peace with the life they've led, with the people in their lives. They feel loved, they feel

> […] accomplished what they needed to do, right? They're proud of what they've done, and they're proud of what? Their families that like their value system may not be family. It may just be, what they value they feel they have achieved but the people who do have anxiety I'm seeing anxiety.

Participant 3 noted encountering patients ready to die, even though they didn't know what that process was and what it looked like. She shared information about death and dying to help them in those final days. "Some patients are ready to die, and you are telling my body I am going to die but they don't know how to die. My responsibility is to assist with providing information concerning death and dying."

Theme three summarized additional lived experiences to those mentioned in theme one that social workers and liaisons working in high-stress environments assisting terminally ill patients narrated. The participants encountered compassion and death anxiety due to interacting with patients anxious about imminent death. Death anxiety was also aggravated by constant exposure to discussions about death. Some hospice workers experienced trauma after observing the challenges of caring for children suffering from mental health illnesses.

Summary of Results

RQ1: What are the lived experiences and self-care practices of hospice social workers and liaisons who work in high-stress environments and who assist with personal care for terminally ill patients?

Three themes emerged. The first theme was hospice work may be overwhelming, stressful, caused burnout, and some workplaces lacked necessary resources. Participants described the nature of work and the working environment that affected self-care. They expressed the work is hard and stressful, which threatened self-care. The work was also overwhelming, leading to burnout. Participants mentioned they advocate for their rights and fight to get the necessary resources to navigate the demands of excess work- and job-related stress. Amongst themselves, they create spaces to vent. Further, they noted that when employers create conducive work environments, it’s a condition that enhances employees’ self-care.

Theme two was hospice social workers practiced self-care strategies by maintaining boundaries from work, doing activities of personal interest, creating time to recharge, leaned on support groups and lived a healthy lifestyle. In this theme, participants described their self-care strategies to mitigate the effects of the hard and stressful work and the sometimes-unconducive working environment. Two key tactics emerged, which were engaging in self-care practices and utilizing group support. Self-care practices covered individual initiatives the participants mentioned they use to enhance self-care. The participants mentioned maintaining boundaries or balance between work and personal life, engaging in activities of personal interest, not answering work phone calls after work hours, finding and creating time to recharge, leading a healthy lifestyle, and consciously understanding self-care as some of the individual self-care practices.

Theme three was hospice social workers may encounter compassion anxiety and vicarious trauma from interacting with terminally ill and suicidal patients. Participants described their lived experiences working with terminally ill patients in this theme. The participants expressed encountering compassion and death anxiety due to constantly interacting with patients anxious about imminent death and constant exposure to a discussion about death. However, participants reported that not all patients displayed anxiety when facing imminent death.

The three themes in this study supported theory propositions that individuals perform certain practices to safeguard their wellbeing. The results showed that hospice work may be overwhelming and stressful and may cause burnout, especially where hospice workers lack the necessary resources. Also, hospice workers -may experience compassion anxiety and vicarious trauma from interacting with terminally ill and suicidal patients. As postulated in the theory that individuals perform certain practices for survival, the study participants practiced self-care strategies by maintaining boundaries from work, doing activities of personal interest, creating time to recharge, leaned on support groups, vented to colleagues and lived a healthy lifestyle as some of the self-care activities.

Summary

This chapter covered the analysis and reporting of the results for the single research question guiding this study which examined the lived experiences and self-care practices of hospice social workers and liaisons who work in high-stress environments and assist with personal care for terminally ill patients. The results suggested the nature of work and the work environment shaped the hospice workers’ experience and influenced their self-care behaviors. Exposure to hospice work may cause compassion and death anxiety. The participants adapted individual self-care practices and leaned on social groups for support to deal with the challenges associated with hospice work. In Chapter 5, I will discuss the findings, present the implications, outline the limitations, suggest recommendations, and draw key study conclusions.

Chapter 5. Discussion, Conclusions, and Recommendations

Summary of Results

The purpose of this descriptive phenomenological study was to understand the lived experiences and self-care practices of hospice social workers and liaisons who work in high-stress environments and who provide care to patients with a prognosis of 6 months or less to live. The problem that I addressed in this study is the growing need for hospice social workers and liaisons, as well as the lack of understanding regarding self-care practices among these professionals. This chapter will summarize the entire study, give an overview of the findings presented in Chapter 4, and present recommendations to inform future research and practice.

Hospice care is an area of healthcare that is growing and will likely continue to grow (Hughes et al., 2019; Wajid et al., 2021). The focus in this study was on hospice social workers who are human service professionals assisting with personal care for patients with a prognosis of 6 months or less to live (Head et al., 2019); hospice liaisons are human service professionals who provide hospice information to patients and the families of patients who are expected to be referred to hospice (Livne, 2014).

According to Eaves (2018), the human service professionals who work in hospice care often struggle to balance their self-care with the needs of patients. Three themes emerged in this study, which supports the theory propositions that individuals perform certain practices to safeguard their wellbeing. The results showed that hospice work was overwhelming and stressful and may cause burnout, especially where hospice workers lacked the necessary resources.

This's study qualitative phenomenological was guided by the theory of self-care conceptual framework. Self-care theory is one of three interrelated constructs that comprise Orem's (1991) self-care deficit theory of nursing. The other two are self-care deficit theory and the theory of nursing systems. Since this study's objectives aimed to explore the lived experiences and self-care practices of hospice social workers and liaisons, self-care theory was found to be the appropriate and helpful research foundation. The theory of self-care provides a construct for understanding human interactions and the ability to learn and apply principles related to caring for the self (Orem, 2001). Every human being is required to perform certain tasks in their daily lives that are critical to their survival, according to Orem, and these tasks are referred to as self-care (Abotalebidariasari et al., 2016; Denyes et al., 2001).

Researchers suggested that self-care is an intimate process by which factors should be considered, such as individual belief systems, cultural, and societal experiences (Pope et al., 2017). In this context, self-care was considered as a way to empower professionals to prioritize one's overall health and well-being (Pope et al., 2017). That was the case, as much of the research founded on self-care theory focuses on the self-care needs and behaviors of patients and clients, instead of the professionals working in healthcare settings.

Interpretation of the Findings

As already established, this study was qualitative and utilized the phenomenological design. A qualitative phenomenological approach was preferred as it enabled the researcher to explore what people have experienced and particularly focus on their experience of a phenomenon. Ideally, this school of thought holds that in order to understand realities, individuals' subjective experiences must be transcended (Kafle, 2011). I collected data by administering 30 minute, semi structured interviews with a sample of seven hospice social workers and liaisons. The sample size was less than the recommended 10-12 participants (Colaizzi, 1978; Sim et al., 2018) because of the participants' availability and voluntary nature of the need to participate in the study. The sampling strategy used included employing both purposive and snowball sampling. A description of the interview protocol, which will serve as the study instrument, is also provided.

The research question below supported the problem focus for this study:

RQ1: What are the lived experiences and self-care practices of hospice social workers and liaisons who work in high-stress environments and who assist with personal care for terminally ill patients?

The findings revealed that the type of social care work a caregiver undertook determined the different experiences they shared. Accordingly, the hospice social workers and liaisons explained that they embraced different self-care practices to navigate the high-stress environment of hospice social work. Three major themes emerged from this study:

1. Hospice work was overwhelming, stressful, caused burnout and some workplaces lacked necessary resources.
2. Hospice social workers practiced self-care strategies by maintaining boundaries from work, did activities of personal interest, created time to recharge, leaned on support groups and lived a healthy lifestyle.
3. Hospice social workers encountered compassion anxiety and vicarious trauma from interacting with terminally ill and suicidal patients.

The first theme confirmed the findings that were reported in the literature. Blacker et al. (2016) explained how the professional roles and responsibilities of hospice social workers can be challenging, as they are forced to navigate between the concerns and needs of multiple stakeholders. Silverman (2016) described that it can be difficult for hospice social workers to navigate between resource management and tending to the needs of terminally ill patients. The prevailing theme showed the healthcare workers feel overwhelmed and stressed due to work constraints, and burnout stood out as a pressing issue as the hospice social workers grappled with working while having limited resources, which reinforced the findings by Kim et al. (2016) and Miligi et al. (2019). Also, the emotional stress and turmoil the healthcare hospice social workers and liaisons face was found to be detrimental on their performance when caring for terminally ill patients (Moore & Sheetz, 2014; Zubatsky et al., 2019). The stress associated with caring for terminally ill patients in palliative care cannot be undermined.

The second theme addressed the aspect of hospice social workers to embrace self-care practices and make their work more manageable. Accordingly, the results confirmed the position of Pereira et al. (2011) and Sanchez-Reilly et al. (2013), who stressed the need to train the professionals on how to protect themselves from stress and burnout that result from their work and being deliberate about caring for themselves. The second theme confirmed the viability and practicality of the selfcare theory, which stated that individuals perform activities that help them to maintain life, health, and wellbeing (Abotalebidariasari et al., 2016; Denyes et al., 2001). In this context, the hospice social workers and liaisons are trying to promote their own mental health, which is likely to affect overall health, and well-being. Accordingly, one can deduce that self-care is paramount for all professionals offering palliative care to terminally-ill patients, as ignoring self-care undermines the health and wellbeing of all involved parties (i.e., the professionals and the patients).

The third theme revealed the aspects of compassion anxiety and vicarious trauma. According to Barnett et al. (2019), compassion anxiety or fatigue describes the emotional and physical exhaustion that results from long-term caregiving. The participants' experience, as reported in this study, confirmed that compassion fatigue develops from empathizing with clients' emotional pain and suffering, and from direct or indirect trauma exposure (Sorenson et al., 2017). Compassion fatigue was found to undermine patient care, relationships with colleagues, and lead to more serious mental health conditions such as posttraumatic stress disorder, anxiety, or depression (Castiglione et al., 2016; Cocker & Joss, 2016; Eaves, 2018; Galanakis et al., 2016; Kwong, 2016; Portoghese et al., 2020). Also, the participants' feedback confirmed Pelon's (2017) assertions that ongoing exposure to the suffering of others and concern for them may foster exhaustion on emotional, physical, and spiritual levels. Besides, as Oginska-Bulik (2018) and Pereira et al. (2011) stated, vicarious trauma is a process defined by individuals who work with those who have experienced trauma becoming so entrenched in helping others that they begin to feel the trauma themselves. In this regard, caring for terminally ill patients in palliative care can undermine the health social worker and liaisons' mental health if no measures of self-care are taken.

Limitations of the Study

No conducted study is flawless, especially given the inevitable nature of research limitations. Limitations primarily refer to the attributes of a study that are potential indicators of flaws (Gao, 2020). As highlighted in Chapter 1, the access to participants in this study was subjective, as it was determined by the researchers' personal contacts and the contacts of identified participants as manifested in the purposive and snowballing sampling techniques, respectively. Some participants might have participated in the study out of a feeling of obligation towards a friend (i.e., the research analyst or fellow participant, as was the case in the snowballing technique). However, it is important to note that the study was voluntary, and no coercion was initiated. That reality notwithstanding, it is likely that the genuineness of the participants' input and feedback may have been threatened. They might have felt pressured to conform to the expectations of their friends who referred them to the study, or who are also involved in the study (Pietilä et al., 2019). Therefore, it was important for the researcher to ensure that the participants are fully informed about the purpose, methods, and ethical considerations of the study, and that they were given the opportunity to withdraw at any time without any negative consequences.

In retrospect, the earlier established limitation of conducting a qualitative study manifested. Specifically, it might be challenging to replicate this study given that research happened in the participants' natural setting. Also, the sample size of seven participants was relatively smaller than an ideal number that would be used in quantitative studies (Emmel, 2015). Accordingly, the sample size undermines representation and in extension, the ability to generalize the study; however, the findings offer insightful themes and possible theoretical saturations that may help to ensure the reliability and validity of the study, as argued by Cypress (2017) and Emmel (2015). A qualitative study like this one may present weaknesses that can be addressed by using a mixed method approach where possible.

A mixed methods approach can address the weaknesses of a qualitative study by combining the strengths of both qualitative and quantitative research methods (Halcomb, 2019). It can help to address the issue of replicability by using quantitative methods to collect data in a more structured and standardized manner, which can make it easier to replicate the study. Additionally, a mixed methods approach can help to address the issue of sample size and representation by using quantitative methods to collect data from a larger and more representative sample, which can, in turn, improve the generalizability of the study (Fofana et al., 2020). The mixed methods approach can be a valuable tool for researchers who want to address the weaknesses of qualitative studies by combining the strengths of both qualitative and quantitative research methods. This can help to improve the replicability, sample size and representation, and generalizability of qualitative studies.

Lastly, there was a risk for researcher biases. I took precautions against interfering with collected data by using the bracketing method. Any information that was not what the participants said was placed in brackets within a journal. By journaling, any preconceived notions, opinions, or biases were recognized and set aside while conducting work on this investigation. The move ensured that the results analyzed in Chapter 4 were purely the feedback acquired from the participants. Accordingly, my own subjective outlook did not interfere with the study findings.

Recommendations

This research addressed an existing research gap, but several recommendations can inform future research. First, researchers conducting future studies may also find out the views of family members who are also caring for terminally ill patients. It would be important to find out whether their experiences are similar with those of the healthcare hospice social workers and liaisons. Getting the highlighted perspective from family members helping to care for terminally ill patients will help different stakeholders in the health sector to make more informed decisions on how to ease the process of providing palliative care to terminally ill patients. The input of caregivers who are also family of the patients cannot be underestimated.

Second, researchers should consider conducting a quantitative study to check the prevalence of the findings manifested in this study. It would be beneficial to find out the percentage of hospice social workers and liaisons who experience the challenges identified in this study, as it would help determine how much of a priority the identified challenge is. If the matter affects a significantly high number of professionals, then it is paramount that stakeholders and decisionmakers invest resources to address the challenge of lack of self-care among those taking care of terminally ill patients when offering palliative care.

Third, linked to using a quantitative research approach, researchers should consider using probability sampling. The current study used non-probability sampling techniques (purposive and snowballing), which are relatively more subjective compared to probability sampling techniques. Objectivity is a critical aspect in research as it determines the validity of a study's findings and the extent of generalizability.

Lastly, there is a need for organizations to hire hospice social workers and liaisons to invest significant resources towards facilitating self-care. While the professionals need to care for terminally ill patients in palliative care, they also need to take care of themselves. Failing to uphold self-care may not only affect the professionals' physical and mental wellbeing, but it may also have a ripple effect and undermine the care quality that patients receive.

Implications

Positive Social Change

The findings reveal that self-care is an important aspect of the professional life of hospice social workers and liaisons. With self-care, the professionals may be able to offer better services while also looking after themselves. The nature of work is critical, and self-care may enable them to be in the right psychological and mental state to care for the terminally ill patients in palliative care. The hospice social workers and liaisons may also be in a better position to handle the patient's family members as well, given that most family members will often be present during the provision of palliative care. Hiring institutions may also likely benefit from having a competent team of professionals without having to worry about attrition and turnovers.

Theoretical Implications

This study addressed the identified research gap as informed by the literature review. There was no study that focused on the lived experience and self-care practices used by hospice social workers and liaisons who care for the terminally ill (i.e., residing in senior-care living centers, nursing facilities, hospitals, and personal residences). As such, this current study was instrumental in adding to the body of knowledge and existing literature information on self-care practices among hospice social workers and liaisons.

Methodology Implications

This current research was a descriptive phenomenological study that aimed to understand the lived experiences and self-care practices of hospice social workers and liaisons who work in high-stress environments and who provide care to patients who have been given a prognosis of 6 months or less to live. While the study incorporated the views of professionals and the experiences they face, a case study could be used as an alternative approach to find out about the identified situation. Also, to determine the prevalence of the identified challenges among professionals, a quantitative study could be necessary, given that the qualitative study mainly focused on non-quantifiable variables. However, it is possible to find out the number of hospice social workers and liaisons who report having challenges with their work and who practice self-care to navigate those challenges.

Conclusion

In conclusion, self-care for hospice social workers and liaisons should be a priority, as self-care may enable the professionals to conduct their tasks and duties more productively. As such, any organizations recruiting and hiring hospice social workers and liaisons need to invest in self-care to achieve a win-win situation for both all parties involved (i.e., the palliative care professionals, the patients, and the institutions that have a staff attending to terminally ill patients). Also, it is important to note that self-care may help the institutions hiring hospice social workers and liaisons to reduce attrition and turnover rates.

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Appendix A: Recruitment Flyer

DOCTORAL RESEARCH STUDY

Exploring the Experiences of Hospice Social Workers Caring for Terminally Ill Patients

Please share your story in a qualitative research study on the Experiences of Hospice Social Workers Caring for Terminally Ill Patients?

CRITERIA FOR PARTICIPATION:

Primary Language English

- ❖ Current Hospice Social Worker who cares for terminally ill patients.
- ❖ Work at the following facilities (long-term care facilities, hospitals, hospice care centers, personal care homes, and in-home care located in North Texas)

If interested in participating in this study, please contact:

RESEARCHER
Cynthia R. Rector, Doctoral Candidate
Walden University, College of Human and Social Services

Your participation in the study would be entirely voluntary, and the information you share would be kept completely confidential, including your name. The stories and information you provide will be used for research purposes only.

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, please contact the Chair of the Human Subjects Institutional Review Board through Walden University
Email: irb@mail.waldenu.edu.

Appendix B: Demographic Screening Questionnaire

Lived experiences and self-care practices of hospice social workers who work in high-stress environments and assist with personal care for terminally ill patients?

The purpose of this form is to screen potential participants to ensure that they meet the criteria for the study.

This research is designed with the intent to minimize the risk to **human subjects.**

My research is designed to focus specifically on the individuals who are ideally suited to answer this study's research question, without burdening others unnecessarily. Now, I would like for you to answer a few questions to determine if you are the best fit to participate in helping to answer this study's research questions through the interview process.

NOTE: the information you share would be kept completely confidential, including your name. The stories and information you provide will be used for research purposes only.

Name: ___________________ Phone: __________________

Email______________

Age: ____________________________

Gender: _________________________

Race/Ethnicity: ___________________

Level of Education: _______________

Occupation: ____________________

Qualifying Questions:

Please confirm that you meet the following inclusion criteria:

- Are you a North Texas Hospice social worker?
- Are you a North Texas Human Service professional?
- In what type of Faculty do you work?
- ___ long-term care facility ___ hospital
- ____ hospice care centers ____ personal care homes ___in-home care
- Do you possess a minimum of a bachelor's degree?

Do you have at least 1 full year of experience as a hospice social worker, and

Please confirm the number of years you have been employed as a hospice social worker or Human service professional.

1 – 4 years

5 – 10 years

11 – 15 years

16 – 20 years

21 years or longer

Could you share your position title?

Please return this questionnaire and consent form to the researcher via email at

Appendix C: Interview Questions

I. Post Recruitment Flyer

II. Follow up with any potential participant via email, sending questionnaire and consent form.

III. Establish eligible to participate in study on the questionnaire and consent form have been returned to researcher.

- If ineligible to participate the following email will be sent.

Insert email

- If eligible the researcher will call the participant using the following script:

(Identify that the correct individual is on the phone or Zoom conference on each call).

My name is Cynthia R. Rector, and I am a doctoral candidate at Walden University's Doctor of Human Service student. I thank you for your interest in possibly participating in my Human Service's Doctoral research study. The research topic that you would participate in is lived experiences and self-care practices of hospice social workers who work in high-stress environments and who assist with personal care for terminally ill patients.

During this interview, I will ask a number of questions relating to self-care practices as a hospice social worker or human services professionals. This interview is completely voluntary. You have the right to withdraw from the study at any point, and for any reason. In addition, you may skip any interview questions you do not wish to answer.

I would like to take the time now to address any question you may have regarding the informed consent that you returned? If you are ready to proceed, I will ask the first interview question.

*(*Researcher gains participants acknowledgment)

VI. Open-ended Interview Questions

1. Please describe the term “self-care” and how it pertains to you?
    a. Prompts: Please describe what if any practices pertain to: physical, psychological, emotional, spiritual, and professional self-care practices.
2. Please describe what compassion fatigue or death anxiety means in the context of working with terminal patients?
3. Please describe your experiences of compassion fatigue.
    a. Prompt: how, if at all has compassion fatigue affected you professionally or outside of employment?
4. Please describe what if any daily self-care practices you employ at home and work?
    a. Prompt: Please describe what self-care support practices mean to you.
    b. Please describe what a *lack of self-care* means to you in the context of your life.
5. Please describe how if at all your employer assists with daily self-care?

6. This is the conclusion of the interview, is there anything that we have not covered, you would like to cover that I did not ask?

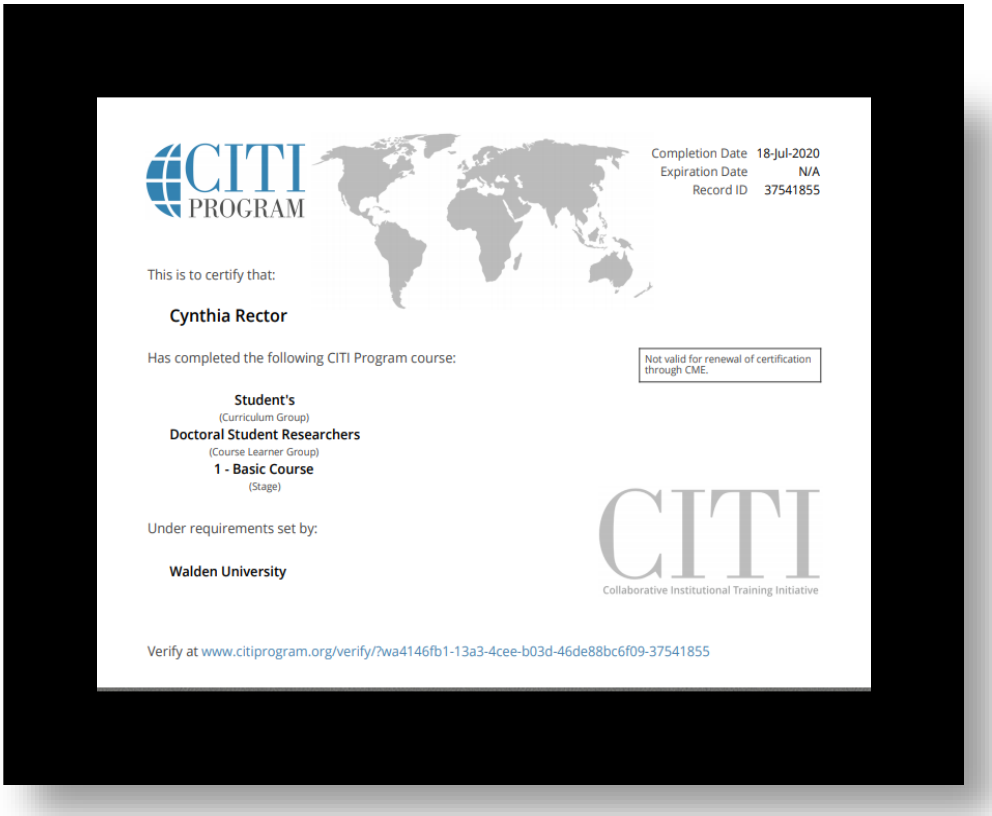
V. Interview Debriefing Steps: (closing interview script.)

This concludes our interview, and I appreciate your participation in my research. The next steps involve me transcribing this interview. Please note that I take your confidentiality as my highest priority. As a result, I will not use any identifying information in the transcript, the final summary, or the research document. Once the transcriptions are complete, I will email you your transcript. I am requesting for you to review transcript and if there are any corrections needed, please send me the updated information within the week of receiving transcript email.

I will employ transcript review as form of member checking to establish the credibility of my results.

Once I am finished with the study, if you wish, I can provide you with the final research results.

Appendix D: Human Subjects Research Course Certificate



CITI
PROGRAM

Completion Date 18-Jul-2020
Expiration Date N/A
Record ID 37541855

This is to certify that:

Cynthia Rector

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Student's
(Curriculum Group)
Doctoral Student Researchers
(Course Learner Group)
1 - Basic Course
(Stage)

Under requirements set by:

Walden University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?wa4146fb1-13a3-4cee-b03d-46de88bc6f09-37541855

Appendix E: Resource List

Dallas Counseling and Treatment Center
4144 N. Central Express Way Suite 850
Dallas, TX 75204
(903)245-4492

The Counseling Center of Texas
13601 Preston Rd. #702
Dallas, TX 75240
(469)646-6350

Wales Counseling Center
2000 E. Lamar Blvd. Suite 600
Arlington, TX 76006
(214)519-9473

Door of Hope Counseling
1201 N. Watson Rd. Suite 177
Arlington, TX 76006
(817)360-2450

Rush Creek Counseling Center
2350 SW Green Oaks Blvd.
Arlington, TX 76006
(817)704-6991

Starfish Counseling
801 Road to Six Flags West, Suite 145
Arlington, TX 76012
(817)459-2433