RELATIONSHIP BETWEEN THE TEAM APPROACH
AND STRESS MANAGEMENT AMONG HOSPICE WORKERS

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by
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RELATIONSHIP BETWEEN THE TEAM APPROACH
AND STRESS MANAGEMENT AMONG HOSPICE WORKERS

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An abstract of a Dissertation by
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This study was designed to determine the validity of the assumption that participation in an interdisciplinary team reduces the stress and lessens burnout of the hospice worker. On-site, semi-structured interviews were conducted with a nurse, social worker, and chaplain from each of seven Medicare-certified hospices in Iowa. Both qualitative and demographic data were gathered. Data indicate that differences exist in perceptions of team integrality and the degree to which the interdisciplinary team decreases and increases stress for each of the three professional groups of hospice workers. Literature related to the study was examined. The field research and the literature indicate that the interdisciplinary team reduces stress to a greater degree than it increases stress for the hospice workers, thus lessening burnout. Using the interdisciplinary team approach in all hospices will reduce the stress experienced by workers and benefit patient and family recipients of hospice services.
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CHAPTER 1

Introduction

Hospice work is stressful because it involves dealing with the emotional and physical pain of patients and families. The relationship between the team approach and stress management of hospice workers is examined in this study. Data from field research with Medicare-certified hospices, which are required to have interdisciplinary teams, and related literature will be presented to further an understanding of this relationship. If the team approach reduces stress, the hospice workers will benefit and so will the recipients of hospice services.

History of Hospice

In medieval times, both hospices and hospitals cared for the sick and the dying. Dying persons were considered to be valuable, prophetic souls who offered opportunities to others for service and spiritual growth. They were seen as beings who, more rapidly than others, were moving forward on the metaphysical plane. An archaic synonym for hospital is hospice. A hospice was an inn or lodging that offered a refuge for pilgrims, travelers, and strangers. The poor, orphans, and women in labor also were welcomed.

The Latin word hospes means both host and guest. Stoddard (1978) says that the modern use of the word hospice seems appropriate to characterize a program designed to assist terminally-ill patients and their families. The term symbolizes the opening of doors to travelers on a journey "into the mystery that lies beyond" (p.226). Craven and Wald (1975) say that the
Word *hospice* suggests that spiritual and emotional care are as important as medical care.

The National Hospice Organization, formed in 1978, defines hospice as "a coordinated interdisciplinary program of supportive services and pain and symptom control for terminally-ill people and their families. Hospice is primarily a concept of care, not a specific place of care" (Cohen, 1979, p. 3). A major aim of a hospice program is relief (palliation) of symptoms to enable the patients to live out their lives as comfortably and as meaningfully as possible, stressing intensive caring at a time when curative treatment is no longer appropriate. Most patients are in the familiar surroundings of their home and are served by community-based hospices. Patients referred to hospices have a limited life expectancy of six months or less.

Wald (1981) categorizes five types of hospices. The first two types are independent of other healthcare agencies: (1) freestanding institutions with beds and (2) offices from which the hospice delivers home care. The other types are (3) a hospital such as St. Luke's in New York where interdisciplinary teams work with terminally-ill patients, no matter what their location within the hospital; (4) separate units for palliative care within hospitals; and (5) hospices with hospital affiliations. Special provisions are made for a relaxation of the rules in the hospital-hospice setting. Wald states that freestanding hospices as well as those associated with a hospital or special institution have home programs--in addition to caring for the terminally ill within their walls.

*Consumer Reports* (Jan. 1986) states that of the estimated 1,700 hospices in the United States, more than 800 are sponsored by hospitals, 300 are affiliated with home healthcare agencies, and 600 are independent. Wakefield, Curry, and Kieffer (1987) report that in Iowa in June 1985 hospice service providers totaled 35. At that time, 10 hospices were in the early
planning stages. At the time of the collection of data for this study in November 1987, eight Iowa hospices were Medicare-certified.

Wald (1981) summarizes the effects of scientific and medical advances on hospitals and the public. New methods for curing and controlling many illnesses promise a reprieve from death. Emphasis on cure diverts the public and healthcare givers away from the acceptance of the inevitable course of certain diseases and toward furthering scientific and medical information. The rapid development and sophistication of medical technology skyrockets costs and depersonalizes patient care. Pathology, not people, becomes central to medical training. A diagnosis is based increasingly upon laboratory tests. Simplicity is gone, and patients worship doctors as omnipotent beings who direct them through the medical maze and make all the decisions. Nurses become monitors, patients are "cases," and social workers join in the movement toward putting the needs of the hospital first. Emotional pain is not acknowledged. In some instances patients are treated aggressively until death. In other instances patients are avoided as much as possible when they serve no further purpose for teaching or experimentation. Wald continues by saying that some terminal patients are sent to nursing homes of questionable standards where treatment of pain is limited or to their own homes where their families are ill-equipped to cope with the problems of the terminally ill. Mauksch (1975) states that the complexity of the modern hospital necessitates routines, rituals, and rules. He says that these sometimes cease to be meaningful, effective, or satisfying--either to the people performing them or to the dying patients who receive them.

The hospice movement began with the expressed need of terminally-ill patients to have palliative treatment for the control of symptoms and to focus on the quality of their lives. Max Weber (1947), a German sociologist, proposed
that every reform begins with dissatisfaction with the existing system and continues with the development of ideas for a new approach. According to Weber, to keep ideas alive, a tension must develop between the idealists who nourish the ideas and the policy makers who institutionalize them. A balance thus is maintained between ideals and realities (Weber, 1947).

Wald (1981) suggests that social changes in the '60s centering on civil rights, women's rights, and Vietnam led the way for open expression in other areas. Critics of the medical system began speaking up, and many were demanding a humanistic approach to the terminally ill. It is within this context that the leadership and organization of the modern hospice concept developed. Dr. Cicely Saunders founded St. Christopher's Hospice in London in the 1960s. In speaking of the modern concept of hospice, she says:

This is indeed a place of meeting. Physical and spiritual, doing and accepting, giving and receiving, all have to be brought together . . . the dying need community, its help and fellowship. . . . The community needs the dying to make it think of eternal issues and to make it listen. . . . We are debtors to those who can make us learn such things as to be gentle and to approach others with true attention and respect. (Stoddard, 1978, p.14)

The influence of Dr. Saunders sparked the development of the first hospice in the United States when she spoke at Yale University in 1963. She and Dr. Elisabeth Kubler-Ross, a psychiatrist in Chicago and an authority on death and dying, became leaders in the movement to challenge the care pattern for the terminally ill. The modern hospice movement that began in England had to be molded to the unique needs and values in the United States. Farrell (1982) states that it is not possible to separate the American way of death from the American way of life. He quotes Alexis deTocqueville's comment on Americans: "The recollection of shortness of life is a constant spur." Americans are occupied with pursuits of life, always wanting more than what
they possess. Their interests do not include death, although Farrell observes that within the past 25 years there is an "unparalleled attempt to understand meaning and management of death in American culture" (p. 107).

Sylvia Lack, in helping to develop a hospice demonstration project in 1974 through a contract with the National Cancer Institute, was warned that Americans are hospital-oriented, and--when they are sick--they want to be in the hospital. She was told further that nobody died at home in this country because our society is not prepared for death at home and that palliative care is against "the American way of life." Under Dr. Lack's direction, hospice used a careful, non-threatening method of introducing the hospice concept to the healthcare community. Efforts to involve visiting nurse associations in planning the program and the nurses' willingness to share the care in many homes were successful and crucial to the effort. Initiating home care without any back-up beds, Hospice, Inc. of New Haven continued that pattern for three years before building a freestanding institution. The organizers found that a segment of the population very much desired hospice services (Lack, 1978).

Agich (1978) contrasts the styles of care encouraged by acute medical and surgical units with the hospice movement--curative vs. well-being. The curative style of care is directed toward returning the patient to normalcy as related to general psychological and biological norms of functioning. The well-being perspective focuses on the patient rather than on the regulatory meaning of care. Craven and Wald (1975) say that the commitment by hospitals to the curative model with the accompanying emphasis on life-saving machinery has made it more difficult to perceive the patient as a human being and part of a family unit.

Craven and Wald also say that when people are dying, what they need most is relief from the distressing symptoms of their disease, the security of a
caring environment, expert care that is sustained, and the assurance that they and their families will not be abandoned. DuBois (1980) states that the strength of the hospice concept lies in its unique and effective way of meeting the special needs of the dying that are not met often within the existing healthcare network.

Noyes and Clancy (1983) discuss the confusion between the sick role and the dying role. In the sick role, the patient realizes the new expectations for his or her behavior, and the patient's obligations toward others. At the same time, the patient's family members, physicians and others in the social system are made aware of their roles in caring for the sick person. Noyes and Clancy explain further that reciprocal obligations exist between the sick and the well. Dependency is encouraged for the sick person, and the goal is to restore the patient to a normal state of functioning. Mauksch (1975) observes that the patient tolerates the regimented lifestyle, along with the diagnostic testing and the nuisance and pain of treatment modalities.

The dying person is cast in this same sick role, according to Noyes and Clancy, except that the patient has a limited life expectancy. In the relatively authoritarian community of the hospital, privacy and autonomy are limited, and the setting encourages dependency. Treatment that is appropriate for the acutely ill may not be appropriate for the dying and may unnecessarily prolong suffering and disability. The hospice philosophy maintains that dying persons should be expected to be independent within the limits of their declining resources. Noyes and Clancy believe that people with fatal illnesses should be cared for in an appropriate setting where a high priority is given to their needs.

Agich (1978), in summing up the styles of care encouraged by the hospice movement and by acute medical and surgical units, says that they pose two contrasts: cure vs. care; normality vs. well-being. The ministering by hospice to the person with limited life expectancy does not focus on restoring
the individual to some scientifically predetermined and socially accepted state of normality. Hospice helps the patient to recover a state of well-being as defined by the patient's perspective and needs, not the perspective and needs of the medical system. Agich also states that although there is some blurring of the word *care* in hospital and hospice usage, the point is to distinguish where the major emphasis is--cure vs. care.

**The Interdisciplinary Team**

Medicare guidelines are specific in the standards that a hospice must meet to become Medicare-certified. One condition of participation is the designation of an interdisciplinary group composed of individuals who supervise or provide the care and services offered by the hospice. This includes establishing, reviewing and updating a plan of care for each individual and conducting an ongoing assessment of patient and family needs. The team also is responsible for developing policies and procedures. The composition of the group must include a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor (Code of Federal Regulations, 1986). The interdisciplinary teams of most hospices also include other healthcare personnel, consultants, volunteers, and office staff.

**Stress**

White (1981) defines professional stress as "the demand for adaptational change experienced in the performance of one's professional role" (p. 295). Stress refers to the state in which the individual organism's well-being is threatened. It becomes a problem only when the demands or stressors exceed the individual's coping mechanism (Beresford, 1986). Stress also may be defined as burnout, "a progressive loss of idealism, energy, and purpose
experienced by people in the helping professions as a result of the conditions of
their work" (Edelwich with Brodsky, 1980, p. 14). The term burnout came into
the professional literature in 1974 when Dr. Herbert J. Freudenberger used it in
an article about staff in alternative, help-giving facilities (Beemsterboer & Baum,
1984).

Price and Murphy (1984) believe that the term burnout is imprecise and
needs a more operational definition. They say that using the term as a static
state or "accomplished fact" may not be as helpful as considering it a
"disordered or 'unsuccessful' process of adaptation to a stressful work situation"
(p. 48). Its use this way, according to Price and Murphy, offers opportunities for
primary and secondary prevention.

Selye defines stress as "the nonspecific response of the body to any
demand made upon it" (1973, p. 692). These responses are unlike such
specific responses as shivering to keep warm or perspiring to keep cool. Yet
nonspecific responses, too, produce a need to adapt to a problem and
reestablish normalcy. The stress-producing factors--or stressors--may be
different, but they produce essentially the same biological stress response.
Stress is necessary to life, but if stress is intense and/or prolonged, resistance
or adaptability gives way to exhaustion.

Maslach (1982) states that the burnout syndrome appears not to result
from occasional crises, but as a response to chronic, everyday stress. In the
helping professions, one's tolerance for the continual pressure of working
closely with people gradually wears away. The caregiver begins to have
problems in dealing with people, and the caregiver shifts "from positive and
caring to negative and uncaring" (p.17). As the caregiver may see no change in
the work environment that might cause a change in attitude, the caregiver feels
quite alone and assumes responsibility for the burnout. This may result in the
development of a negative self-concept. The identifiable reason may be overload, emotional or physical. Maslach defines stress as a burden that a person is unable to handle.

**The Study**

To determine the relationship between the team approach and stress reduction of hospice workers, the literature will be searched for pertinent information. A field study of the Medicare-certified hospices in Iowa will be made. To be Medicare-certified, a hospice must have an interdisciplinary team that includes a nurse, social worker and chaplain. Each hospice will be asked to make available a member of each of these professions to participate in an on-site, semi-structured interview. Qualitative data and demographic data will be gathered and presented.

The data the study yields will be a basis for determining the relationship between the team approach and stress reduction. This study is predicated on the assumption that participation in an interdisciplinary team reduces stress and lessens burnout of the hospice worker.
CHAPTER 2
Review of Literature

The Hospice Concept

Before the 19th century, dying was regarded as a natural part of the life cycle and was shared by the immediate and extended families. Lev (1986) states that the technological and medical advances during and after World War II began escalating costs and depersonalizing care for the terminally ill, whose care had shifted from the family to the hospital. The hospice concept became the response to the need for alternative care.

Kastenbaum (1978) discusses the meaning of our cultural bias to want to be in control. He says that many in our society see death as a total loss and that "the stress of a dying person arouses everyone to control, control, control" (p. 238). Kastenbaum suggests that our society needs to learn to "let go" when a person is on the brink of death.

"The time for terminal care is reached when all active treatment of a patient's disease becomes ineffective and irrelevant to his real needs" (Saunders, 1978, p. 22). Koff (1980) states, "For the first time, successful and effective care is not equated with recovery and cure" (p. vii). According to Koff, the usual traditional care for the dying often prolongs suffering and extends life without regard to the quality of that life. He also says that traditional care disregards the dignity of the patient and unnecessarily isolates the patient from the home environment, family, and friends when they are most needed by the patient. In addition, Koff points out that expenses for traditional care may be exhorbitant.
Silver (1981) states that in hospice care "The emphasis is on treatment of the whole person rather than the disease, palliation of symptoms instead of further aggressive but futile therapy" (p. 307). For pain control, the National Cancer Institute (n.d.) recommends a regular schedule of pain medication rather than having the patient request medication when the pain becomes unbearable. Pain takes energy, and the patient needs all available energy to live life as fully as possible. The National Cancer Institute suggests that "staying on top of the pain" is the best way to control it and may require lower doses of pain reliever.

According to Rossman (1979), hospice adjusts to the varying lifestyles of the patient and family needs whereas in the hospital setting, the patient and families adjust to the "unyielding regimen of the hospital" (p. 61). He continues by saying that the hospice patient and family are encouraged to be active in making decisions and determining the quality of life for the patient. Cohen (1979) states that quality of life for the dying means "maintaining real life as long as possible, ensuring that the patient is alert and comfortable, capable of enjoying family and surroundings, not desensitized by pain and anxiety" (p. 28).

Rossman (1979) asserts that dying people have a right to be cared for by caregivers who will not abandon them and who will enable the patients to live life as fully as possible in a positive atmosphere, not one of gloom. Rossman states that the attitude of the caregivers is critical. They need to affirm palliative care when the patient's condition is such that aggressive treatment in an attempt to delay death results only in prolonged misery to the patient and family.

**Stressors**

The mere entry into hospice work may become a stressor. Vachon
(1978) suggests six major reasons for working with the dying, although she states that other reasons might be equally valid:

1. Accident, convenience, or a part of one's caseload.
2. A desire to do the "in thing" or to affiliate with a charismatic leader.
3. Intellectual appeal, that is, the desire for control and mastery over illness, pain, and death.
4. A sense of "calling" in religious or humanistic terms.
5. Previous personal experience[---]either one's self or with those close to him or her.
6. The suspicion that one will someday develop the disease. (p. 115)

Vachon (1986c), in a talk given at the National Hospice Organization Management Conference, states that some young, single people who think they know what they want come into hospice. If hospice does not meet their needs, they leave. Vachon says they often come into hospice without life experience and totally "fall apart." Then they say, "Gosh, no one ever told me that people live like this and people die like this."

In discussing the special risks of hospice work for nurses, Stockton (1986) states that the reasons (some of which Vachon mentions) people take up hospice work are not always altruistic. Stockton's suggested reasons are an "unnatural" interest in death, a need to be needed, a desire for assurance of worthiness, a wish to be part of an "in" agency, an opportunity to do for others what was not done for their loved ones, or seeing a need and addressing it. Stockton says that some workers are in hospice because of convenience or just by accident.

Lattanzi (1981) believes that career choices in stressful areas are best made if the person applies the "same principles of decision making, health-related behaviors, and principles of caring and support " to him/herself as well as to the clients. "Insight into our personal needs, vulnerabilities, and expectations is an element in ensuring flexibility in job functioning. It can also
be important in preventing overinvolvement, dissatisfaction, or rigid responses to clients" (p.350).

Friel and Tehan (1980) categorize stressors as originating in the individual's external environment (exogenous) and originating in the individual's internal environment (endogenous.) They offer these examples of exogenous stressors: (1) the fact that all hospice patients die; (2) the diseases have distressful symptoms; (3) the work is physically and emotionally demanding; (4) sometimes care cannot be controlled in the home because of the family; and (5) organizational factors cause difficulty.

Endogenous stressors mentioned by Friel and Tehan include: (1) the pressures which are self-imposed; (2) emotional involvement with the patients and families and loss of those relationships; and (3) disillusionment about idealistic expectations of hospice.

Friel and Tehan state that patients and their families are under tremendous stress, and that this affects the hospice workers. Members of the families are dealing with their own emotions about the impending death and often generate feelings that affect their interpersonal relations. Most families have not experienced dealing with the terminally ill and are apprehensive, anxious, unsure, and need much reassurance and support from the hospice workers. These writers continue by saying that the needs of the patient are great, as well, because of psychological, spiritual, emotional, physical, and sometimes financial issues that need to be addressed.

Korda (1987) comments that in the hospice setting, one of the main exogenous stressors is the worker's continual exposure to the dying process and the physical and psychological conditions associated with it. Vachon (1986a) says that caregivers can be emotionally and physically drained by constant exposure to the dying. They come to know their patients intimately and
may become personally involved in the suffering that the family is experiencing. Pattison (1978) uses the term *death saturation*. He says that caregivers can work only so long with dying persons with so much intensity and personal involvement before the caregivers reach the end of their tolerance.

Korda (1987) writes that as the "recipients of hospice care are so vulnerable and their need for genuine human involvement so acute, the providers of that care must be fully available—physically, intellectually, emotionally, and spiritually" (p. 40). Korda also states that a basis for burnout may be workers expecting to meet all the needs of the patient and the family. Hospice workers need to have realistic expectations of themselves according to Larson (1985). He states that self-doubt and self-blame usually are associated with feelings of guilt, a consequence of the unrealistic expectations.

Vachon says a worker may have difficulty choosing between wanting to administer to the needs of the family and taking care of the worker's own needs. Rossman (1979) says that hospice workers will not be able to handle the burdens of teamwork if their emotions are drained constantly by working with the dying and if they have no way of replenishing their emotional energy.

Vachon, Lyall, and Freeman (1978) found that on the Goldberg General Health Questionnaire (GHQ) that the Palliative Care Unit (PCU) nursing staff had higher stress scores than new widows or patients beginning radiation for breast cancer.

Maslach (1982) states that a clear relationship exists between age and burnout in the helping professions. Younger workers are more likely to experience burnout than those with increased age and life experience. She does point out that the older workers may be the survivors—those who manage to handle early the threat of burnout. Maslach finds a consistent relationship
between marital status and burnout, with single people experiencing more
burnout.

Maslach (1982) also finds that workers with families are even less likely
to have burnout. These workers tend to be older, more stable, and
psychologically mature individuals. Maslach suggests that parents are more
used to dealing with personal problems and emotional conflicts than workers
without families. The family provides an emotional resource, fulfilling many of
the worker's needs for approval and affection so that there is less likelihood of
seeking personal gratification from clients or colleagues.

Anyone who makes a vocation of helping others is vulnerable in many
ways, according to Edelwich with Brodsky (1980). One of these ways is "There
but for the grace of God, go I," and imagining oneself in the role of the real or
potential sufferer. Another is "the helper's need to be needed," and giving of
oneself beyond an emotional safety margin for self, while at the same time, not
wanting to be totally responsible for the other person. If the reason for helping
others is confirming one's own sense of power over others or for making the
world a better place, the worker is vulnerable to burnout. These writers also say
that the sensation of powerlessness is a universal feeling when one cannot
change "the givens."

Working exclusively with terminally-ill patients carries the potential of
high stress. Hospice caregivers are "confronted with the depression and
demoralization of patients, the desperation of patients' families, and the
disillusionment of co-workers in the face of great personal and professional
challenges" (Larson, 1986a, p. 41). Staff members, on a personal level, may be
overwhelmed by the highs and lows of emotions, may feel burdened by a sense
of responsibility for the patients, and may experience a drain of energy because
of desires to reach out to meet multiple needs (Munley, 1985). According to
LaGrand (1980), various somatic complaints are caused by physical and emotional stress. He says, for example, that neuro-muscular hypertension can lead to headaches, backaches, and upset stomachs.

Korte (1985) says that in addition to constantly facing the issue of terminal illness in a patient and the high level of anxiety of the caretaker and/or family, the hospice worker has to deal with his or her own mortality. In spite of technological changes, death reminds us of human vulnerability. Pruyser (1984) states that the caregiver constantly is forced to face the existential message that "life is a going-to-death--inevitably, irrevocably, unalterably" (p. 359). Pruyser quotes the inscription on the Roman tombstone: Hodie mihi cras tibi—today it is me, tomorrow it will be you. He goes on to ask, "Who can escape that confrontational verity?" (p.358)

In studying the causes of stress, Yancik (1984b) used a self-administered questionnaire to obtain data from 93 caregivers at three freestanding hospice facilities. Eighty-nine responded. Among other questions, she asked the respondents to describe the three most stressful events they had professionally experienced in the last three months. Yancik reports that over 50 percent of the stressful situations involve the hospice workers and issues of staff support. More than half of these situations involve personnel conflicts and administrative problems. Approximately 37 percent of all reported stressful events are related to patients and their families. Management of the disease process constitutes approximately 11 percent of all of the stressful events.

Mor and Laliberte (1984) found that full-time paid hospice workers scored higher on the Emotional Exhaustion and Depersonalization factor structure of the Maslach Burnout Inventory. This suggests that the intensity of exposure to stressful factors, together with the duration of exposure, increases the likelihood that the individual will experience burnout.
A study by Masterson-Allen, Mor, Laliberte, and Monteiro (1985) also indicates that in hospice a strong relationship exists between burnout and working full-time with direct patient contact. Intense involvement with patients experiencing psychological and/or physical problems can be emotionally and physically exhaustive. The study suggests that younger staff are more prone to burnout than older staff, and that hospice workers with a higher degree of education have a greater possibility of burnout. However, the study also shows that workers with a higher degree of education experience greater feelings of accomplishment.

Maguire (1985) points to the likelihood of burnout for workers who are dedicated to their work and who have no other special interests or outside support systems. Usually, Maguire says, these workers are ambitious, have high ideals and standards and keep problems to themselves.

Munley (1983) states that hospice workers who want to "make a difference" about how a patient experiences death may find that their failure to achieve a difference is stressful. She goes on to say that stress can manifest itself in the relationships with patients and families. While hospice has the ideal of love and caring, it is a community "with warts." Munley indicates that patients, their families, and staff members can be less than lovable. The frustrations and anxieties of patients and families are sometimes projected in anger upon the hospice helpers, according to Munley. A demanding patient may be manipulative or a difficult patient may present distressing symptoms, causing an inner conflict within the worker between idealism and negative feelings. Also, family members may cause conflict by arguing in front of the patient about money or property.

Munley (1983) continues by saying that a drawn-out "death watch" is another stressor. She says that when a patient is "actively dying" for five or
more days, to the worker and to the family that period "seems like an eternity" (p. 204). Munley (1985) says that sometimes the sudden death of a patient leaves the hospice worker with a feeling of "being cheated" or not having had a chance to "complete unfinished business" (p. 346).

Munley (1983) also reports that even though death with dignity is a noble concept, death does not always have dignity. She goes on to say it is difficult to watch some deaths, for example, when the disease has resulted in mutilation, external tumors, or emaciation. According to Munley, sometimes the possibility exists that the patient will hemorrhage or convulse at the time of death, and the worker becomes concerned how the family will respond to such events.

According to Feigenberg (1980), frustration to the caregiver occurs when that person tries to impose chronological time onto the patient. Sourkes (1987) states that the orderly "unfolding of time" changes as the patient faces loss of identity, loss of control, and loss of relationships. Focus is on the present for patients and families, "framed by the themes of separation and loss" (p. 22).

Feigenberg (1980) speaks of existential time as the expression of the meaning of what happens to a human being in the present. It cannot be measured like chronological time; the future belongs to chronological time and is an illusion. What the dying person has left is existential time. Feigenberg suggests that the dying patient should not be criticized; the patient's view of time is not "wrong"; it simply is.

A preconceived standard of death for patients, e.g., "with dignity" should not be urged or forced upon patients as it amounts to subjection, even if done unintentionally. Only the patient knows what "dignity" is for the patient (Feigenberg, 1980). Pattison (1978) states that whatever is consistent with the dying patient's definition of the meaning of death and the patient's own life context, is an appropriate death. He suggests that in a worker's zealou
do something," the worker may overlook the fact that "just being" may be most comforting to the patient. Davidson (1978) states that denial of death "is an appropriate and, for some patients, final characteristic of dignity insofar as it is part of one's spiritual quest" (p. 147).

Butler (1979) agrees that there is "no right way to die." Some terminally-ill patients will struggle to hold on to life, and workers should consider this a normal response. Butler says that each person has a unique life course, and that each death will be unique. It may be that the person engages in a life review in response to an impending death. Butler says that hospice workers must recognize that each patient needs to come to terms with death, but that it has to be a highly individualized experience.

Lannie (1984) states that a hospice worker with a rigid personal belief system, who cannot accept or "be with" a patient whose way of facing death differs radically from what the worker believes is "right," feels stress keenly. To have the ultimate goal of facilitating peaceful acceptance of death by hospice patients results in stress for the worker. "Why would a 20-year-old mother ever fold her hands and peacefully say of her death, 'It's okay?'" (p.34)

Homer (1984) says, "Dying people make us anxious" (p. 138). She proposes that there are two levels of anxiety. The first relates to both conscious and unconscious conflicts regarding "loss, abandonment, and one's own mortality which are unresolved," (p. 139) and these keep surfacing with each death the worker experiences. Homer uses psychoanalyst Melanie Klein's model and says that the second level of anxiety is on a deeper, more primitive level. Klein suggests that infant destructive fantasies are reduced somewhat by projecting and discharging them onto the "object-mother." Klein then says the infant moves into a "depressive position" where there is guilt over the fantasies.
If the guilt is not worked through with maturity, it can surface when a mother-child relationship is established by the nurse with the patient.

According to Pattison (1978), responding to what the patient is experiencing in facing death means responding to the worker's own feelings about death. Pattison says that one must be "empathically sensitive" and, at the same time, must keep one's "psychic composure and objectivity" so that one can be as helpful as possible to the dying person within the context of that person's life. Klass and Hutch (1985-86) state that "one's acceptance of death always precedes life."

Munley (1983) states that the death of a favorite patient is especially stressful. Vanderbent (1986) describes her feelings:

I have experienced the absolute horrors of a dying patient and the soft, sad, heavy feeling one has after the death of a special person. I have suffered the therapist's peculiar form of grieving where you are not really a part of the family system and experience the sadness of isolated loss and professional regrets. I have had patients die while I was away on holiday or unavailable and felt somehow cheated and angry at the damned injustice and futility of it all. I have been, and probably always will be, haunted by patients who will live on in my memory for many years. (p. 35)

Pattison (1977) suggests a posture of "compassionate detachment" rather than "exaggerated detachment" or "exaggerated compassion." In exaggerated detachment, a clinical-like view is maintained. In the exaggerated compassion, a "fusion with the dying" takes place, and the worker goes through his or her own past guilts, shames, and death experiences as well as future death anxieties.

Pattison (1978) discusses the ambivalence a patient can arouse in the caregiver. He says that not only may the caregiver have feelings of tender and loving compassion; the caregiver also may feel disappointment, despair, and sometimes even hatred. Some thoughts and feelings are termed "helper
secrets" by Larson (1985). The worker may harbor feelings of inadequacy and incompetency, doubts as to basic motives for being in hospice work, personal guilt and sometimes hostility and hate toward patients and other workers. Embarrassing and disturbing thoughts include a love/hate relationship--being emotionally involved with a patient and yet, at the end stage of the illness, wishing the patient would die. Larson also states that in trying to distance oneself emotionally and thus decrease emotional involvement, one experiences even more stress in a "stress-avoidance-guilt" sequence.

According to Stockton (1986), sometimes hospice nurses feel unworthy when they are told that they are special and are given compliments. She says:

We know we are often tired and irritable, lacking in patience, wishing for a patient's death because his dying isn't good--as it's supposed to be--even wishing for a person's death because we are just fed up with dressing his stinking wounds, listening to his complaints, or having to put up with his freaked-out family. Good nurses don't have bad feelings, do they? We see others on the team coping perfectly well, and question our own suitability for the job. We want so much to live up to those assurances of how splendid we are. . . . No wonder we are burning out. (p.62)

Munley (1983) uses the term "pit and peak experiences" to reflect the lows and highs of hospice workers. Of the highs, she says, "moments of insight, of meaning, of strengthening awareness of the richness of human experience and of the purposefulness of their work" are "gateways" to a fuller awareness of life and death. Munley speaks of the emotions of "awe, wonder and reverence" that hospice workers sometimes feel (p. 222).

Pattison (1977) states that it is not realistic to expect only positive attitudes toward death in ourselves or in others. Dying people are not always nice or likeable, and hospice workers may be angry and frustrated by patients and their families. Pattison says that some deaths cause sorrow, some bring a sense of relief, and some may possibly bring "vindictive feelings of satisfaction."
He recommends that workers integrate positive and negative feelings, "filter" feelings through their consciousness, and then act with responsible integrity to themselves and to the dying.

Hillix, Harari, and Mohr (1979) say that the people who share secrets feel more positive about the listeners, just as the listeners feel more positive about the tellers. Larson would agree as he believes sharing helper secrets can strengthen relationships and "promote the personal and professional growth of the caregiver" (p. 40). Larson (1985) recommends sharing these secrets in a safe environment, e.g., with empathic co-workers. Embarrassing and guilty feelings are normalized, and the one who shares usually finds out that others have had similar uncomfortable and distressing feelings.

Rubin and Beckhard (1972) speak of internal role expectations. Different members of the group have different expectations of others' role behavior as the group works together to achieve a common goal. These writers say that the following concerns exist in any group: "(1) the extent to which such expectations are clearly defined and communicated (role ambiguity); (2) the extent to which such expectations are compatible or in conflict (role conflict); (3) the extent to which any individual is capable of meeting these multiple expectations (role overload)" (p. 319). Lowe and Herranen (1981b) state that to function successfully in a team, "each member must maintain an equilibrium between his/her internal values and ideas and external expectations" (p. 1050).

The Rev. Dawson (1980) says that the hospice chaplain is continually under pressure to supply answers to patients and families, and that sometimes their questions are not answerable in rational terms. "We cannot be God, nor must we play God—but we can in priestly fashion represent Him to those who look to us for help, and we can offer them to Him at the throne of divine grace. Sometimes that is all we can do, and having done it, we must let go and go
about our work" (p. 65). Dawson states that the chaplain must be careful not to impose his or her prejudices upon a patient, but to accept the patient where that person is and to be sensitive to the changes in spiritual posture that may take place.

As a social worker, Vanderbent (1986) contends the impact of palliative care upon professionals has not been given sufficient attention. She says that "working with the dying requires a great tolerance for ambiguity and also an ability to preserve one's own boundaries in the midst of a family's turmoil" (p. 35). A worker risks burnout if the worker takes emotional risks without understanding the need for limits. Vanderbent believes that unless the social worker realizes that both the social worker and the patient have "emotional hurdles," the social worker cannot offer "quality care." Feelings of frustration, rage, and helplessness block out productivity.

Vanderbent says that the social worker, in working with intangibles, has "nowhere to hide." The social worker is not dealing with physical aspects that can be "seen, measured, and medicated." Vanderbent observes that sometimes patients redirect their anger toward the worker or sometimes simply reject the person. The worker finds it risky to try again with the patient. According to Vanderbent, unrealistic high expectations of others and the feeling of having to prove one's own usefulness cause stress.

In the hospice setting, the social worker's role sometimes is difficult to define. A question to Dr. Dale Larson appears in the *Hospice Team Quarterly* (1986c).

I am a social worker in a hospice program in a home health agency. One of the major problems I'm experiencing is a lack of acceptance and professional recognition by both staff and volunteers in our hospice program. Sometimes I feel as if I'm not treated as a part of the team, and that families almost resist my help because they don't want to be branded as having "social problems." (p. 6)
Yancik (1984b) reports that time pressure is a general source of stress for hospice workers. One nurse says that no matter how fast she works, she can "barely do the job she would like to do. . . . The patients and their families have great emotional needs and require a lot of listening and caring. This takes time" (p. 25).

Edelwich with Brodsky (1980) cites the frustration of paperwork. He quotes a typical remark: "You spend so much time writing down what you have done and what you're going to do that you don't have time to do anything" (p. 116). As part of a study by Krikorian and Moser (1985), hospice nurses ranked 53 stressful activities. Frustration with health care bureaucracy ranked 2, administrative factors ranked 5, while paperwork and record-keeping ranked 6. Krikorian and Moser recommend that administrators develop programs to facilitate understanding bureaucracy and to find ways to make record-keeping more efficient.

**Interdisciplinary Teams**

Unique factors of hospice in the health care field include: (1) treating the patient and family as a unit of care, and (2) employing an interdisciplinary team approach to care management (O'Meara, 1985). Hospice workers differ from other healthcare specialties in that they have "team philosophy, team support, and team building as the most frequently reported coping mechanism" (Vachon, 1986a, p. 76). The team is central to the hospice program as no one person can meet all of the diverse needs of the dying patients and their families. "A strong, supportive team is one of the most important factors in delivering consistent high quality care" (Tehan, 1982, p. 15).
Bloom and Parad (1976) speak of a "synergistic effect" which is created when team members of different disciplines feel a strong sense of shared responsibility and function well together. Bloom and Parad also suggest that the cumulative outcome is greater than the effects of each individual working separately. Larson (1986c) states that "the essence of interdisciplinary team work is to bring the specialized talents and resources of all team members into a concerted caring effort" (p.6).

Corliss (1983) states that as hospice care is more than coordination of care from a variety of caregivers, scrupulous attention needs to be given to the physical, psychological, social, and spiritual aspects of the patient and family group. This requires catalyzing of communication and connectedness with them. Lowe and Herranen (1981a) say that the essential ingredient of communication among team members leads toward coordination of team skills, transcendence of professional roles, and cultivation of shared values--all for the benefit of the patient and family.

Underlying the team approach is the concept that no individual has all of the expertise necessary for the care of the patient and family. Donovan (1984) says that a team does not exist just because it is called a team. Wilson, Ajemian, and Mount (1978) state that a highly skilled and experienced team is not fashioned overnight, but is built slowly with careful selection and thoughtful nurturing. These writers say that the interdisciplinary team needs to learn each other's languages, resolve to break down interprofessional rivalries, leave defense attitudes aside, and learn how to know, trust, and listen to each other.

Naomi Brill (1976) says the following definition is basic to all teamwork:

A team is a group of people each of whom possesses particular expertise; each of whom is responsible for making individual decisions; who together hold a common purpose; who meet together to
Brill suggests that each team member brings to the team both the personal self and the working self, which can never really be separated as each affects the other constantly. The ability to function comfortably in a highly fluid situation and be open to change in the self as a person and as a worker, is especially important to maximizing the effectiveness of the team. Brill sees a team being made up of interrelated parts, existing in a state of dynamic balance. As in a hanging mobile, a change in any one part causes a change in the other parts. The "glue" that holds the team together is the common purpose toward which all the team members' work is directed. Brill says that the transactional process of working together creates a totality greater than the sum of each working alone. Lack (1978) states that in terminal care there is no room for "turf guards."

Kane (1975b) suggests that team members are first individuals, then professionals, and even later members of interprofessional teams. She says that it is difficult to judge whether the professional or personal attributes best explain an individual's behavior. Team members also bring to the group the different roles the members have played in other groups. A new team member brings unique individual qualities to the group and may not know the established standards of behavior and beliefs (norms) of that particular team. According to Kane, some norms may not be conducive to good interprofessional teamwork. In Kane's opinion, norms that are not supportive of praise or conflict are dysfunctional. Norms against praise deny members the reinforcement that they should receive from the group, and norms against conflict may impede professional judgments.

Rae-Grant and Marcuse (1981) point out that a paradox may exist when individually strong team members become a weak, inefficient team.
Participants may use the defensive measure of the team's protective mantle to avoid coping honestly with feelings that their patients engender. Thus the team may diminish the effectiveness of individual team members.

The notion that an ideal team exists is a myth, according to Rossman (1979). It is his opinion that highly motivated and skilled persons will always have some fundamental disagreements. If the goals are visionary and the programs idealistic, there is more likelihood of conflict. Donovan (1984) believes that working together in partnership will decrease conflict and allow freedom for achievement of professional realization if each member maintains mutual respect for others' knowledge and contributions.

Vachon (1983) states that the use of a well-organized interdisciplinary team is one of the most effective ways of reducing staff stress. Communication among staff members is enhanced, and no one feels completely alone in caring for a patient as responsibility is shared. LaGrand (1980) says, "It is important that professionals support and understand each other so that team members can help each other set limits, release emotional pressure, and facilitate tension release" (p. 67).

Munley (1985) states that one of the causes for disagreement and stress in staff interactions is the subtle pressure to create "ideal deaths." She says that although the hospice ideology emphasizes that there is no "right way to die," hospice workers sometimes forget the uniqueness of each patient. In attempts to have the patients live as full a life as possible before death, workers often try to bring about an acceptance of death. Munley suggests that this tendency to "mold patients" needs to be addressed.

Vachon (1986b) led a discussion in which the focus turned to control issues and hospice workers. One of the workers in the group said that
sometimes control was taken away from the family and patient. The question was, "Is this what you need or is this what the patient needs?"

Dale Larson (1986b) says that one of the problems interdisciplinary teams sometimes have is that the members do not always understand what other disciplines are about. He indicates that this might be because of the professional educational process. Doyle (1982) states that some basic education for all professionals could be structured to facilitate learning the skills other professional workers have to offer. He gives the example that doctors should no longer regard nurses as "handmaidens of the medical profession"; they should respect nurses for their special skills. He goes on to say that nurses need to be empathic in working with new doctors and realize the limitations of many of our diagnostic methods. Doyle suggests that a better understanding of the training and approach of social workers and chaplains is needed. His recommendation is that members of teams work together to share the responsibility and to support each other.

In discussing the preparation of social work students, Zelinsky and Thorson (1983) recommend that studies specifically include how to work with dying patients and their families. Zelinsky and Thorson say that courses in gerontology and thanatology make the students more sensitive to issues of aging and death. As part of their work, students need to explore their own feelings and anxieties related to death and participate in supervised practicums.

Rainey (1983) states that among the things that healthcare students need to learn are how to suggest alternatives and adopt strategies that will help terminally-ill patients achieve limited goals. He says that goals do not have to focus on death and dying issues. A confused family member may need to be encouraged to ask more questions of the oncologist. Perhaps a lonely patient needs to know how to validate friends and helpers so that this patient may have
more interactions. Rainey also says that students "can suggest and support new role enactments for the patient--such as relaxing in the presence of formerly anxiety-provoking stimuli such as a chemotherapy procedure" (p. 296 [210]).

According to Korte (1985), many nurses do not have sufficient preparation to constructively deal with the process of dying and death. She says that formal nursing and inservice education should include a study of the main areas of anxieties about death.

Lev (1986) states that although virtually all healthcare professionals care for the terminally ill sometime, almost no formal curriculum is available to prepare them for the special demands of that work. Lev says that the courses that are available are "more didactic than clinical," but recommends a combination didactic and clinical course designed by the College of New Rochelle. This three-credit course uses the hospice program of care as a framework and is offered to upper-division nursing students in the baccalaureate program.

A problem Larson addresses is that frequently there is one person on the team who wants to do everything. Larson (1986c) states that interdisciplinary teams in hospice often are composed of "highly independent professionals who entered hospice precisely because they loved their autonomy and prided themselves in being 'one-person interdisciplinary teams.'"

An additional issue Larson (1986b) points to is that sometimes one team member may overlap the role of a co-worker who then feels threatened professionally. Pryuser states that a degree of perfectionism exists, an inner urgency, and sometimes "a bit of childish grandiosity" that together may make workers feel inadequate and have a "shaky self-regard" because of their high expectations for themselves (p. 358).
Kane (1975b) states that a profession is sometimes viewed as an area of exclusive competence; however, overlapping skills and interest are apparent when professions collaborate in team activities. She says that social workers have no function that "is legally preserved," and because social work has a broader scope than most professions, it has difficulty defining its "functional specificity" (p. 14). Kane adds that because social work deals with everyday living, lay people believe that they also have some expertise.

Donovan (1984) suggests that the nurse and social worker should make the initial assessment visit together, discuss their findings afterward, and bring their ideas to the team to develop a plan of care. Donovan says "the potential for conflict automatically decreases because collaboration in the psychosocial area of care has begun at the earliest possible stage" (p. 22).

Heintze (1986) states that in Hospice of the Valley of San Jose, California, the roles of the nurse and social worker are blurred. Constant communication enables them to work closely and cooperatively. Heintze gives the example that the social worker is comfortable giving backrubs or personal care while doing counseling, and the nurse offers social and psychological support for the hospice patients. He says that as nurses become aware of the personal and emotional needs of the patient and family, they pass such information on to the social workers. When the social workers become aware of unfulfilled patient and family needs, they share that information with the nurses.

Vachon (1986a) borrows from Mount and Voyer (1980) who observe that "when enthusiasts say 'we work as a team,' they might appropriately be asked to show their scars as proof" (p.66). Kane (1975a) states that a significant portion of the literature on the interprofessional team is concerned with reducing tensions and disagreements and promoting team integration. She says that
honest disagreement is necessary to a team, because both conflict and cooperation are part of problem-solving.

Muldary (1983) states that the probability exists that many problems in interpersonal relations are grounded in the conflicting perceptions that different individuals hold. Distorted perceptions can lead to consequences that are potentially damaging to professional relationships. Kane (1975b) says that team stress is caused by not discussing professional roles openly; there may be incongruities between the way professionals perceive their role and the way other professionals perceive it. Sometimes professionals who feel that their self-perceived role is not accepted by their colleagues may misjudge others' perceptions.

Lowe and Herranen (1981a) state that role overlap and conflict in a team are inevitable, due to the nature of the need for the interdisciplinary team itself. Role overlap and conflict can be a great source of strength or a great source of liability to the team. These authors say that to have a successful team, the members must be flexible and yet have a clear understanding of and confidence in their own roles. Lowe and Herranen suggest that team members sometimes focus on conflict, instead of regarding conflict as part of the process of being a team.

Hospice team members must understand their own roles and yet recognize that overlaps occur, according to Anderson, Neal-McCollum, and Span (1985). If a patient asks the social worker to join in prayer, it is not appropriate for the social worker to tell the patient to wait for the chaplain's visit. However, these writers recommend that the social worker inform the chaplain. Likewise, if the family asks the chaplain to read a letter they have received about obtaining food stamps, he should not refuse, but should tell the social worker about it.
According to Larson (1986b), a basic struggle exists in a team between cooperation and competition—working together or separately. He feels the success of a team is directly related to the degree its members are open to conflict. A personal vulnerability is involved in teamwork as one's skills are exposed for critique by others. Issues of control and feelings of superiority and certainty may lead to resentment and defensiveness. Larson recommends "antidotes" to this defensiveness: "empathy, problem orientation, openness, and encouragement." He suggests that personal learning is involved in teamwork, and that the worker needs to look at the self. Larson continues by saying that the team needs to pool their resources and look toward mutually agreed upon interdisciplinary interventions.

Rossman (1979) suggests that the process by which team members come to trust each other and work together is hard work and cannot be neglected. "Just as a person's health deteriorates if neglected, so also does the health of team functioning" (p. 198). He goes on to say that a team needs to be open and able to talk about areas of conflict. A team needs to be aware of, and work with, individual strengths and weaknesses. However, Kane (1975a) states that too much attention to group processes is counterproductive. She uses the analogy of car maintenance: that "some routine servicing makes the car run better and prevents future breakdown, but when the car is constantly being maintained, its effectiveness for transportation is reduced" (p. 29).

Pruyser (1984) says, "A team is much closer to a living organism than to an administrative system" (p. 366). Effective teams need to grow and mature. Pruysyer states that members of such a team learn of each other's strong points, weaknesses, and idiosyncrasies and give mutual aid and caring. Yancik (1984b) cites a case where a hospice worker was bitter about "the lack of support and recognition from my peer group after a meaningful encounter with a
patient and his family." The worker said, "I really needed some 'strokes,' but got almost indifference and rejection. It really hurt" (p. 26).

Doyle (1982) suggests that support in one's work demands understanding, sensitivity, and sympathy, and that a real team proves itself by its ability to support each member. He says that many teams can grow into happy, balanced maturity without burnout if there is humility on the part of each professional, generosity to recognize the good in colleagues, and the readiness both to work and to play together with the good of the patients as the ultimate goal.

Being the only social worker in a hospice may result in a feeling of professional isolation for that worker, according to Blanchard, Osborn, Dick, and Kelty (1985). They say that one of the common frustrations is "being pulled in too many directions" by too many people and not pleasing anyone. Blanchard, et al, go on to say that this may come from not having a clear role definition, or from not having realistic expectations of what one can accomplish. These authors helped establish a support group of social workers and report that the support group members realize the necessity of a healthy self-image, the value of recognizing one's own skills and those of team members, and the need for trust within the team. Blanchard, et al, say that the group sees the need for communication among team members, not only about patients and their families, but also about the team process. The group also knows that certain tasks may be done by a variety of people.

Judy Donovan (1984) points out the potential for conflict between the nurse and the social worker. She states that the conflict arises when a nurse or social worker intervenes without telling the other and without working cooperatively with the other. "A one-to-one relationship, once established, is not easily forfeited by either" (p.21). Donovan says that these two professionals
may not be secure in their own roles or may misinterpret the other's intent. The workers must lose their sense of territoriality and share information. "Neither the hospice nurse nor the social worker should carry on a private practice under the guise of teamwork" (p.22). As the objective is to meet the patient and family's needs, the nurse and social worker, as well as the other members of the team, should work together. Donovan says that mutual respect for each other's contributions and expertise will decrease conflict and allow for freedom of professional achievement.

Kane (1982) states that integration of the social service and the medical service is needed. She states that focusing on the medical model creates an artificial division, and that the situation would not be bettered by focusing on the psychosocial model. Collaboration between the two professions should be approached from "a collegial rather than an adversarial stance" (p.316).

**Coping with Stress**

Harper (1977) defines coping behavior as "all of the mechanisms utilized by an individual to meet a significant threat to his psychological stability and to enable him to function effectively" (p. 20). These mechanisms include behavioral responses to environmental factors and the worker's intrapsychic processes that help the worker to master the situation. Harper states that every worker needs to develop a personal coping mechanism to deal with death and dying. In turn, this person can offer more strength and support to the patient and family. Harper continues by saying that one needs first to reflect on death and its various meanings. She says that there can be intervention in the dying process and help can be given without feeling that one's efforts lead nowhere.

The definition of coping given by Cherniss (1980) is "efforts to manage demands and conflicts which tax or exceed the person's resources" (p. 45).
Cherniss says coping may be cognitive, behavioral, or a combination of the two. The worker attempts to change the "person-environment relationship" so that demands are lowered and resources are strengthened. Perceptions may be modified by altering attitudes. Cherniss gives an example: "Oh, well, it really doesn't matter that much if I can't do this," and states that by minimizing the harm, neither the demands nor the resources need adjustment (p. 45). Cherniss further states that although coping can be adaptive, over a period of time it can become maladaptive.

Respondents to a survey conducted by Garfield, Larson, and Schuldberg (1982) indicate a need for more training on staff burnout. The authors report that while 76 percent of the hospices already offer training, 65 percent of the hospices see a need for more training in staff burnout. These writers report that more than 50 percent of the respondents also want more training in patient, family, and staff issues, and interpersonal skills.

Atchley, Cohen, and Weinstein (1974) state how a team gave support to workers experiencing grief. "Through interdisciplinary meetings, the staff was able to examine how their defenses against their grief (over a patient) were interfering with their ideal of professional care. They were able to permit themselves legitimate expression of what was warm and caring and human without feeling overwhelmed, guilty, and manipulated" (p. 133). A study by Chiriboga, Jenkins, and Bailey (1983) indicates that hospice nurses who are able to cope best under stress are able to admit their anguish to themselves and to others--yet maintain a professional attitude.

Stockton (1986) says that "gripe sessions" should be held once a month, and closing conferences should be held for each deceased patient. At that time, the workers should share feelings, both good and bad, about the patient. Management of the case may be discussed as a growth experience. Stockton
says that as time is not always available for such activities, each worker must learn to feel good about himself or herself. The worker needs to know that other workers also have problems, even though they may not be apparent. Stockton concludes that it is important to have one's own self-help program if a support group is not available. She says that it is not selfish to think of one's self; if a worker cannot function, the patients will suffer.

While potential benefits may develop from social interaction within a frustrated staff, the interaction may result in a negative effect. It can degenerate into a "bitch session" that makes the participants feel worse and leads to no improvement of the situation (Cherniss, 1980).

LaGrand (1980), in analyzing conflict and its accompanying anxiety, says that conflict reveals how people "communicate, relate to, and respect each other" (p. 63). He says that often unintentional remarks are misinterpreted and increase tension. Team members need the understanding and support of each other. LaGrand states that the members need to help each other set limits, allow for release of emotional pressure, and release of tension. He goes on to say that not everyone responds to a situation with the same amount of tension, and that this offers a special opportunity for team members to help each other.

Cherniss (1980) states that inservice training can assist team members to develop coping skills. While conflict resolution and organizational problem-solving are probably the most useful, Cherniss says that helping the staff to budget time better has a positive effect on overload reduction. Cherniss emphasizes that awareness training for the causes and symptoms of burnout are essential to prevent the problem from becoming severe.

Bailey, Carney, Grodski, and Turnbull (1987) describe the support system for nurses developed by the freestanding Connecticut Hospice, Inc., in Branford, Connecticut. Although such different forms of support as one-to-one
encounters of only two or three minutes, social events, scheduled days off, and structured group activities were helpful, the staff concluded that this support was not enough. The fear was voiced that as the staff increased, the team members might not get to know each other, and "might become task oriented and might jeopardize the spirit of hospice" (p. 32). To cope with stress and to renew commitment to quality hospice care, "Rekindling Days" were established as an annual two-day event to explore issues and share concerns. Participants typically feel that this event is successful.

Harmer, Cameron, Pero, and Lepore (1986) describe the development of a support group for hospice nurses in Eastern Montgomery County in Pennsylvania. The nurses identify their stressful feelings and learn to deal with them. They also learn how to take more time for themselves and their interests outside of the hospice situation. Harmer, et al, state that expressing grief is difficult for many nurses, and the group has not yet found a way that is successful in helping members work through their grief. These authors continue by saying that memorial services offer one way for nurses to express grief and have time for quiet reflection.

If the conditions of the work environment do not fit the hospice worker's psychosocial characteristics relative to the individual's skills, abilities or needs, the imbalance produces job stress that may affect the person's well-being (Yancik, 1984a). A study made by Yancik indicates that the internal resources of self-esteem and amount of control over stressful situations (mastery) are effective in coping with emotional stress. Yancik finds a positive relationship between being satisfied with one's hospice work (role fulfillment) and social supports (help from others, and cooperative work.) Yancik suggests that improving the quality of the hospice work experience and strengthening the social support network in a hospice will help to alleviate stressors.
Munley (1983) states that most coping strategies are a blending of different categories. Being with one's own family members and friends not connected with hospice, enjoying hobbies, pursuing aesthetic or creative activities, taking classes on stress management, and "just relaxing" are stress reducers that focus on life. Munley also names verbal and emotional ventilation by self-talk (determining the cause of stress and deciding how to deal with it); "talking it out" with a family member, friend, or peer; or "crying it out." Munley says that other coping mechanisms include physical activities, diet, rest, social drinking, and the spiritual pursuits of quiet reflection, meditation, and prayer. "Leaving work at work and home at home" are effective distancing strategies, according to Munley.

Basile and Stone (1986-87) state that administrative concerns for hospice workers should include focusing on the development and refinement in team members of the competencies related to emotional and interpersonal abilities. Beresford says that ways hospice administrators can help workers manage stress include:

- dealing with the physical environment itself--noise, light, atmosphere;
- providing adequate supervision as well as consistent and positive reinforcement; the availability of a psychologist/psychiatrist consultant;
- flexible personnel policies such as freely available time off, changing work assignments and less than full-time jobs; allowing opportunities for personal growth such as educational opportunities and varied job experiences; encouraging staff awareness of personal stress and dynamics; and clarifying team goals and individual staff roles. (p.6)

Vachon (1978) sets forth some basic administrative principles to help hospice workers cope with stress. Individuals should be encouraged to learn about themselves and acknowledge their own limits. They need to have a healthy balance between work and outside life. For example, Vachon says that time periods should be arranged when staff are totally off-call. Workers should be aware that the "need to be needed" can become so great that the worker
attempts to be everything to everyone instead of using the team approach. Vachon suggests that those who are working in isolation need to consider meeting with an outside counselor or consultant who can provide support.

Tehan (1982) recommends that to reduce the considerable stresses in hospice care and avoid burnout, "the individual organization of each hospice program necessitates specific and tailored approaches" (p. 16). She comments that the administrators set the tone and create the staff environment. Further, administrators need to build into the system flexible mechanisms to reduce the stress of workers. Tehan gives the example of a supervisor allowing time off for personal leave if a staff member obviously needs a break.

Korda (1987) states that only the interdisciplinary team can address the multiple needs of patients and their families; it is an integral part of hospice care. "Great emphasis is placed on the interdependence of team members because the intensity of effort required to meet those needs can be diffused so as not to be overwhelming to individuals" (p. 43).

Lattanzi (1981) states:

The delivery of care and services through an interdisciplinary team approach provides a network of mutual support and learning available to all involved. While the interdisciplinary team framework provides limited external structure and less clearly defined roles, it offers the blending of input from a variety of professional perspectives, the availability of back-up and support in difficult situations, and diversity and flexibility. Interdisciplinary team functioning balances some of the toll associated with working with individuals who are in the most painful of life circumstances. (pp. 350-351)

**Conclusion**

The literature suggests that team membership in the hospice setting most frequently decreases stress, although it sometimes increases stress. Field research on the Medicare-certified hospices in Iowa, discussed in Chapter 4 of
this dissertation, yields more information on the relationship between team membership and stress.
CHAPTER 3
Methodology

The relationship between the team approach and stress reduction among hospice workers is further understood through an analysis of data gathered in on-site field research in Iowa. Medicare requires an interdisciplinary team; therefore, a nurse, social worker, and chaplain in seven of the eight* Medicare-certified hospices were interviewed. The semi-structured interview method that was used allowed for broader input by the interviewees. Qualitative data was supplemented with demographic data to provide more information.

Letters were sent to the directors or coordinators of seven of the eight Medicare-certified hospices in Iowa stating the purpose of the study and requesting permission to interview professional workers. (Hospices are named in Appendix A.) The letters also suggested dates and time schedules between November 16-24, 1987, for all the sites and included self-addressed, stamped return envelopes. All of the hospices contacted responded favorably. One social worker, one chaplain, and one nurse from each hospice participated in the study, totaling twenty respondents.** If more than one worker from each discipline was affiliated with a hospice, the director or coordinator was asked to determine the interviewee by random selection.

* Hospice of Central Iowa was not included as the writer interned there.
** One social worker was not interviewed as she had been employed only five days.
The questions in the semi-structured interview were designed to gather data to assess the validity of the assumption that participation in an interdisciplinary team will reduce stress and lessen burnout of the hospice worker. As part of the interview, cards with questions were presented to the interviewees. (The interviewer’s worksheet is reproduced in Appendix B.)

As a measure of reassurance and to engender a more detailed study, the interviewer first inquired into how the worker came to be in the hospice setting, the length of service time, the work schedule, vacation schedule, and sick-leave policy. Related questions addressed educational background and team meetings. By treating less sensitive material first, the interviewer sought to build trust and rapport, making it easier to deal subsequently with more sensitive topics (Lofland & Lofland, 1984). At whatever time seemed appropriate during the interview, the interviewer inquired about the worker’s marital status, family, and the family’s feelings about the respondent’s hospice work. Additional questions covered the respondent’s church affiliation or religious preference, if any, and respondent’s approximate age.

The balance of the interview was directed toward the hospice worker’s perception of the relationship between the team approach and stress management. Any additional information volunteered by the respondent was also addressed. The interviewer asked for examples and elaboration concerning the following questions, handing the respondent one card at a time:

- On the card I have given you with the question and designations, what is your perception of the amount of stress you experience in your day-to-day work?
  
  --No Stress
  --Slight stress
  --Moderate stress
--Great stress
--Very great stress

- On the same scale, what is your perception of the amount of stress you experience on intense days?
- When was your last intense day?
- What do you perceive to be the sources of your stress?
- How do you deal/cope with your stress? (Interviewer followed up with appropriate probing questions.)

- On the card I have given you with the question and designations, what is your perception of your being an integral part of the interdisciplinary team? That is, how much do you feel you are an integral part of the team? (Your involvement in or importance to the team?)
  --Not at all
  --Slightly
  --Moderately
  --Very significantly
  --Totally

- Using the same scale, what is your perception of the chaplain's/nurse's/social worker's (appropriate two) integrality in the interdisciplinary team? (Their involvement in or importance to the team?)
  - How often does the team meet?
  - Is the meeting formal?
  - If not, are there informal meetings?
  - Are there informal ways of accomplishing hospice work?
  - On the card I have given you, how does the interdisciplinary team, collectively or individually, affect your stress?
--Increases the level of stress
--Decreases the level of stress
--Both increases and decreases the level of stress
--Neither increases nor decreases the level of stress

- On the card(s) I have given you with the question and designations, what is your perception of the degree to which the interdisciplinary team decreases (or increases) your stress?

- No decrease  -- No increase
- Slight decrease  -- Slight increase
- Moderate decrease  -- Moderate increase
- Great decrease  -- Great increase
- Very great decrease  -- Very great increase

- Under what circumstances does the interdisciplinary team decrease (and/or increase) your stress?

The semi-structured interviews, lasting approximately 45-50 minutes, were audiotaped with the consent of the respondents. The interviewer also took limited notes in case of a mechanical failure. Tape recording the interview reduces the tendency to make an unconscious selection of data favoring the interviewer's biases, and the tape may be played back more than once so that what was actually said can be studied more thoroughly (Borg & Gall, 1983). The writer transcribed all of the tapes for reference.

The interviewer's approach was to indicate understanding of the interviewee's responses without showing either approval or disapproval. Except for the cards requiring limited responses, the interviewer made neutral, open-ended inquiries. When needed, techniques of probing were used, such as repeating the question, pausing expectantly, and repeating the respondent's reply. Neutral questions included the following: Anything else? Any other
During the first few minutes of the interview, the goal was to establish rapport with the person interviewed. The interviewer stated that the purpose of the study was to gather data on stress management of interdisciplinary team members and expressed appreciation for the help of that particular individual. The interviewer assured the person that no names would be used in the study report, and that no specific information would be associated with the worker's particular hospice.

A post-interview thank-you letter was sent to each director or coordinator and to each person interviewed. Later, the researcher sent these persons a brief summary of the overall findings.

The interview method for gathering information offers flexibility; the researcher can make full use of the responses of the subject to alter the interview situation. This permits the interviewer to follow up leads and thus obtain more data and greater clarity. The interview situation may permit much greater depth than other methods of collecting research data (Borg & Gall, 1983). "Face-to-face interaction is the fullest condition of participating in the mind of another human being" (Lofland & Lofland, 1984, p. 12).

The qualitative research study allows a more emotional kind of understanding, gained through interaction with the subject, and may yield more satisfactory explanations than more logically precise explanations achieved through mathematical modeling (Bailey, 1987). All types of relationships are uncovered with "hard" data, but only through the use of "soft" data are these relations "explained," and the purpose of research is to explain (Mintzberg, 1983). One of the applications of a qualitative research study is to provide depth and detail. "The data are open-ended in order to find out what people's
lives, experiences and interactions mean to them in their own terms" (Patton, 1980, p. 22).

The term "triangulation," as used by Todd Jick, suggests that the accuracy of a researcher's judgments can be improved by "collecting different kinds of data bearing on the same phenomenon" (1983, pp. 135-136). This would include blending qualitative with quantitative data, even on a simple design scale. The quantitative data in this study are intended to enhance the qualitative research data.

Means, medians, frequencies, and ranges are the descriptive statistics used with the quantitative data from interviews. In computing the mean and median of workers' ages, Early-age categories are given the value of the appropriate multiple of 10, while the Late-age categories are given the appropriate multiple of 10 with a 5 then added (E30s=30; L30s=35). Designations on the cards are assigned 0 for None or Not at All; 1 for Slight or Slightly; 2 for Moderate or Moderately; 3 for Great or Very significantly; and 4 for Very great or Totally.

A descriptive summary of the data is discussed in Chapter 4 and evaluated in relation to the assumption on which this research study is based: that participation in the interdisciplinary team will reduce stress and lessen burnout of the hospice worker. Each area of inquiry is addressed in regard to the interviewees as a whole, and then in regard to each professional group. Similarities and differences of the groups are discussed. Perception responses to team integrality, stress levels, causes of stress, and means of stress reduction serve as a basis for drawing conclusions concerning similarities and differences among workers. Further discussion of the demographic data provides additional insight.
CHAPTER 4

Findings

Characteristics of Hospice Workers

Data gathered in the 20* semi-structured interviews with nurses, social workers and chaplains in Iowa Medicare-certified hospices are presented here in text and tables. Of the five independent hospices, two office in a hospital but are not affiliated with the institution, and one is associated with a home-health agency. The other two hospices are under hospital administration. One of the latter is a small hospital and has a room specifically designated for resident hospice patients. One of the community-based hospices contracts with a hospital for a large room to be used only by hospice patients.

One of the hospitals containing a nonaffiliated hospice has a six-room wing for hospice patients. The hospital staff in the unit espouse the hospice philosophy. The rooms are furnished comfortably in a home-like fashion. As one interviewee said, "Each one is like a birthing room except that the patients are leaving, rather than entering the world." One terminally-ill boy who could no longer stay home was allowed to keep his rabbit and kitty in his room as his parents were with him all of the time. His dearest desire was to see his pony once more, and that was quietly arranged "when the coast was clear" by wheeling him down to the back hall of the hospital where his pony stood. Canaries are kept in the hospice-wing office in case a patient might enjoy feathered company.

* One social worker was not interviewed as she had been employed only five days.
The reported reasons for being a hospice worker overlap. Allowing only one reason per interviewee, the results are shown in Table 1. Seven are hospice workers because they have always been interested in hospice; five are in hospice because of hospital assignments; two are influenced by parental home experiences; two are working at the request of hospices; two see the need for chaplains; one feels crisis ministry is a part of total ministry; and one is a hospice worker because of a newspaper advertisement. The group of seven who have always been interested in hospice is composed of six nurses and one social worker. Of those workers assigned by hospitals, three are chaplains, and two are social workers.

<table>
<thead>
<tr>
<th>Reason for Becoming Hospice Workers</th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have always been interested</td>
<td>6</td>
<td>1</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Hospital assignments</td>
<td>2</td>
<td>3</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Parental home experiences</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Request of hospices</td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Saw need</td>
<td></td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Crisis work part of total ministry</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Newspaper advertisement</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

One social worker says that her interest in hospice developed when her father, worried and fearful and with his pain out of control, died of cancer. Her mother had to work and was finding the situation very difficult. The social worker decided at that time a better way surely must be available for handling terminal illnesses. In her graduate studies she learned about hospice and,
upon graduation, found employment with a hospice. She says that one cannot go back, but one can look to the future and help other families.

The respondents were asked for their approximate ages, e.g., Early or Late 30s. Using that example, Early 30s was considered by the researcher to be 30-34; Late 30s was considered to be 35-39. E30 was given the value of 3.0; L30 was given the value of 3.5. As shown in Table 2, the ages of all respondents range from Early 20s to Early 70s with a mean of 39.0 years and a median of 37.5 years. The nurses have an age range from Early 30s to Late 50s with a mean of 39.3 years and a median of 35.0 years. Ages of social workers range from Early 20s to Late 30s with a mean of 28.3 years and a median of 30.0 years. The chaplains have an age range from Early 40s to Early 70s with a mean of 49.3 years and a median of 50.0 years. As a group, the social workers are younger than the nurses, and the chaplains are older than other groups.

Table 2
Age of Respondents

<table>
<thead>
<tr>
<th></th>
<th>E20</th>
<th>L20</th>
<th>E30</th>
<th>L30</th>
<th>E40</th>
<th>L40</th>
<th>E50</th>
<th>L50</th>
<th>E60</th>
<th>L60</th>
<th>E70</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Workers</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chaplains</td>
<td>3</td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>39.3</td>
<td>35.0</td>
<td>E30-L50</td>
</tr>
<tr>
<td>Social Workers</td>
<td>28.3</td>
<td>30.0</td>
<td>E20-L35</td>
</tr>
<tr>
<td>Chaplains</td>
<td>49.3</td>
<td>50.0</td>
<td>E40-E70</td>
</tr>
<tr>
<td>Total Group</td>
<td>39.0</td>
<td>37.5</td>
<td>E20-E70</td>
</tr>
</tbody>
</table>
Months of service for all respondents range from 2.5 months to 84.0 months (seven years) with a mean of 33.5 months and a median of 36.0 months (three years) as shown in Table 3. The nurses have a service range from 11.0 months to 60.0 months (five years) with a mean of 38.7 months and a median of 48.0 months (four years). Months of service for social workers range from 4.0 months to 60.0 months (five years) with a mean of 22.3 months and a median of 9.0 months. Chaplains have a service range from 2.5 months to 84.0 months (seven years) with a mean of 39.4 months and a median of 48.0 months (four years). Four social workers, three chaplains, and one nurse have served for a year or less. Three chaplains, two nurses, and one social worker have served for five years or more.

<table>
<thead>
<tr>
<th></th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months or less</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>7 - 12 months</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>18 months</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>26 months</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>46-48 months</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>60 mos. (5 yrs.)</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>84 mos. (7 yrs.)</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>38.7</td>
<td>22.3</td>
<td>39.4</td>
<td>33.5</td>
</tr>
<tr>
<td>Median</td>
<td>48.0</td>
<td>9.0</td>
<td>48.0</td>
<td>36.0</td>
</tr>
<tr>
<td>Range</td>
<td>11-60</td>
<td>4-60</td>
<td>2.5-84</td>
<td>2.5-84</td>
</tr>
</tbody>
</table>

Information about the work schedule of the hospice workers is given in Table 4. Three interviewees are full-time hospice workers and have two weeks of vacation. Two of these workers have sick leave of one day per month which
may accrue to 50 days. The third worker does not know the specific sick-leave policy. Five workers are part-time to three-fourths time. One of these five works 12 hours per week, and one has weekly hours which vary from 25 to 40. The other twelve workers spend 5 hours to 2 1/2 days weekly with hospice and have other employment with hospitals, home healthcare agencies, or parishes. In professional groupings, five of the six social workers work part-time with hospice; four of the seven nurses are part-time and have other employment; and the chaplains are hospice workers from 5 hours to 1 day per week.

One nurse with small children states that she can handle her stress if she works part-time. She needs to have a clean house and well-kept children or she feels pressure. Another nurse finds that the "getting well" aspect of her part-time work with the associated home health agency helps her to maintain a sense of balance about her terminally-ill patients.

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Work Schedule of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nurses</td>
</tr>
<tr>
<td>Full-time</td>
<td>2</td>
</tr>
<tr>
<td>Part-time*</td>
<td>1</td>
</tr>
<tr>
<td>Part-time to 3/4 time</td>
<td></td>
</tr>
<tr>
<td>Part-time with other employment</td>
<td>4</td>
</tr>
<tr>
<td>5 hrs. weekly to approx. 1 day**</td>
<td></td>
</tr>
</tbody>
</table>

*Includes one 12-hr. week
**Also parish ministers or hospital chaplains

Education of respondents ranges from a three-year nursing diploma to a D.Div. candidacy, as shown in Table 5, and does not include Continuing Education Units (CEUs) or other training. Two nurses have three-year nursing
diplomas, one has an associate's degree and most of a bachelor's degree, one has a B.A. and a two-year associate's degrees, one has a B.S.N. degree, one has a B.N. degree, and one has an M.S. degree as well as an R.N. degree. Three of the social workers have B.A. degrees, two have M.S.W. degrees, and one has an M.S. degree. One chaplain is certified in pastoral care, two chaplains have M.Div. degrees, one has a M.Theology degree, one has an M.A. degree and training in pastoral care, one has an M.M. degree and training in pastoral care, and one chaplain is a D.Div. candidate. Of the respondents, six chaplains, three social workers, and one nurse have master’s degrees.

Table 5
Education of Respondents

<table>
<thead>
<tr>
<th></th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Yr. Nursing Diploma</td>
<td>2</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Certification in Pastoral Care</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Associate's Degree &amp; Most of Bachelor's</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bachelor's Degree</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Bachelor &amp; Associate's Degrees</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master's Degree</td>
<td></td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Master's Degree &amp; RN</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master's Degree &amp; D.Div. Candidate</td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Note: Does not include CEUs and other training

As shown in Table 6, six of the respondents are Catholic, six are Lutheran, three are Methodist, and five are of various other Protestant denominations. Of the seven nurses, one is Catholic, two are Lutheran, two are Methodist, and two have other Protestant preferences. Four of the chaplains
are Catholic, one is Lutheran, and one is Methodist. The three Protestant chaplains were the only males of the twenty respondents in this study.

Table 6

Religious Preferences of Respondents

<table>
<thead>
<tr>
<th></th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Lutheran</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Methodist</td>
<td>2</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Other Protestant Preferences</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 7 shows the marital status and families of respondents. Ten workers have a spouse and children at home; three have a spouse or significant other and grown children; one is separated and has a child; one has a spouse and no children; and five are single, including three renunciants.

Seven nurses, four chaplains, and three social workers are parents. Those with whom the workers live are supportive of their hospice work.

Table 7

Marital Status and Families of Respondents

<table>
<thead>
<tr>
<th></th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse &amp; children at home</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Spouse or signif. other &amp; grown children</td>
<td>2</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Separated &amp; child</td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Spouse, no children</td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Single*</td>
<td>2</td>
<td>3</td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>

* Includes 3 renunciants
One nurse reports that her husband or sons occasionally go with her when she needs to check briefly on a patient. She states that her sons have changed their attitude toward death and have become more accepting of it. This was reflected when one son was critically ill and said that he was not afraid to die—he just wanted his death to be fast.

**Stress Among Hospice Workers**

The degrees of stress experienced by the interviewees are shown in Table 8. Stress on an average day for all of the respondents has a mean of 1.7 on a scale of 0-4, with 0 indicating No stress and 4 indicating Very great stress. The stress for nurses on an average day has a mean of 1.7; for social workers, a mean of 2.0; and for chaplains, a mean of 1.4.

Two nurses and four chaplains report slight stress on an average day; five nurses, the six social workers, and three chaplains report Moderate stress.

Stress on a tense day for all of the respondents has a mean of 3.2 on the same scale with the last tense day ranging from Yesterday to 6 months. Two of the workers do not specify their last tense day.

For the nurses, the mean for a tense day is 3.0. Two nurses report their last tense day as Yesterday, two report Last week, and three report 6/Few months ago.

The mean for social workers on a tense day is 3.3. Two state their last tense day was 2-5 days ago, two state Last week, one states 2-3 weeks ago, and one states 1 month ago.

Chaplains have a mean of 3.1. One reports the last tense day as Last week, three say 2-3 weeks ago, one says 1 month ago, and two do not state a time.
### Table 8

Stress Perceptions of Respondents

<table>
<thead>
<tr>
<th>Stress on an average day</th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0) No stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Slight stress</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>(2) Moderate stress</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>(3) Great stress</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>(4) Very great stress</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Mean of stress on average day</td>
<td>1.7</td>
<td>2.0</td>
<td>1.4</td>
<td>1.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stress on a tense day</th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0) No stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Slight stress</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>(2) Moderate stress</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>(3) Great stress</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>(4) Very great stress</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean of stress on tense day</td>
<td>3.0</td>
<td>3.3</td>
<td>3.1</td>
<td>3.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last tense day</th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yesterday</td>
<td>2</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2 - 5 days ago</td>
<td></td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Last week</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2 - 3 weeks ago</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>1 month ago</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6 / Few months ago</td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Not stated</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Range of last tense day</th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yesterday - 6 mos.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 da. - 1 mo.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last wk. - 1 mo.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
On a tense day, one nurse and one chaplain have Moderate stress. Five nurses, four social workers and four chaplains have Great stress on a tense day; one nurse, two social workers and two chaplains have Very great stress on a tense day.

Four social workers report their last tense day as being from 2 days ago to Last week; the last tense days of all social workers are within a month. Five of the chaplains indicate a time-span from Last week to 1 month; two do not state the time. Two of the nurses report their last tense day as being Yesterday; two report it as being Last week, and three nurses report it as being 6/Few months ago.

A summary of the causes of stress stated by two or more workers is shown in Table 9. Fourteen stressors are given by members of all three of the disciplines. Nine stressors are reported by respondents from two disciplines.

Table 9

Summary of Causes of Stress Stated by Two or More Workers

<table>
<thead>
<tr>
<th></th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient &amp; family</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>Work-related</td>
<td>17</td>
<td>8</td>
<td>11</td>
<td>36</td>
</tr>
<tr>
<td>Personal</td>
<td>9</td>
<td>9</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>Administration</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Interdisciplinary team &amp; team individuals</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>31</td>
<td>27</td>
<td>98</td>
</tr>
</tbody>
</table>

Five stressors are reported from single disciplines. The stressors are categorized under five headings. The first group deals with problems inherent in the patient and family. Work-related stressors, for purposes of this study, are
"part and parcel" of the daily life of a hospice worker. The category of personal stresses involves the reactive responses of hospice workers—the internal stresses as a result of working with the terminally ill. The fourth category is administration-related stressors; the fifth group of stressors is related to the interdisciplinary team and team individuals.

Four stressors are given by respondents in the patient and family category as shown in Table 10. Avoidance of death issues is one of the causes of stress expressed by one nurse, three social workers, and one chaplain. The nurse tells of a 50-year-old patient with children at home whose physician and family did not speak of death to her. She became unresponsive without any opportunity to work out things with her family or to have any sort of closure with them. A social worker experiences stress when patients and families deny the illness and the outcome and do not want to plan ahead. The chaplain speaks of her stress when patients and/or families choose not to discuss death after the chaplain has introduced the subject. She respects their freedom of choice but says that she feels the shock of death would be somewhat lessened if the issue were addressed.

One nurse, one social worker, and three chaplains report stress caused by dysfunctional families. The nurse tells of stress over a family conflict when the dying patient would not reconcile differences with his brother. The social worker tells of going into a home where there are both anger and unresolved issues. One chaplain relates that in the silence of death, the chaplain felt the hostility of the family members toward each other.

Poor communication within the family is reported as stressful by two nurses, one social worker, and two chaplains. A nurse cites a stressful case in which the patient and family "play games." The patient is aware of his imminent death and does not wish to distress the family; the family members are
knowledgeable of the prognosis, but they want to withhold that information from the patient as it might cause him undue distress. The social worker feels stress when she is aware of poor communication in a family but no one wants to speak of it. A chaplain relates the stress of being aware of poor communication within the family and trying to work with them individually, then together, to mute the differences.

Table 10

<table>
<thead>
<tr>
<th>Patient &amp; Family Causes of Stress Stated by Two or More Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses Social Workers Chaplains Total</td>
</tr>
<tr>
<td>Avoidance of death issues 1 3 1 5</td>
</tr>
<tr>
<td>Dysfunctional family systems 1 1 3 5</td>
</tr>
<tr>
<td>Poor communication within family 2 1 2 5</td>
</tr>
<tr>
<td>Patient &amp; family indecision 2 1 1 4</td>
</tr>
<tr>
<td>Totals 6 6 7 19</td>
</tr>
</tbody>
</table>

Two nurses, one social worker, and one chaplain refer to stress caused by patient and/or family indecision. One nurse finds it stressful when a family does not want the patient’s life prolonged by extraordinary measures, but they remain indecisive about requesting No Code. A chaplain speaks of two patients who could not make up their minds about going on a respirator. A social worker tells of the stress caused when a patient used up all of the hospice days allowed by insurance. She was expected to die soon after her prognosis, but she was extremely independent and would not allow herself to die. She would mow her lawn and then become so exhausted that she was debilitated. Also, she refused to take pain medication because she wanted to drive her car. She had no caretaker and kept changing her mind about where
to go when she no longer could stay in her home. The social worker would make arrangements for one place, and then the patient would decide she wanted to go somewhere else.

Work-related stressors, as shown in Table 11, may involve patients and families, but are not necessarily caused by them.

First visits to patients and families are reported as stressful by one nurse and one chaplain. The nurse relates that her work is hard for her until she gets to know the patient and the family. The chaplain says that ministering on a first visit is difficult because she does not know what the expectations of the patient and the family are.

Two nurses describe the stress of communicating the hospice concept when making referral calls. The presentation causes the patient and/or family to think about "this final step" and the limited life expectancy of six months or less. The nurse reports one referral as saying, "Does the doctor think I'm going to die?"

One nurse and two social workers find stress from the faulty perception of the social worker's role by patients and families. The nurse reported that patients may say that they do not need a social worker only because they do not understand what the social worker does. One social worker states that some patients connect her with welfare work and say to themselves, "Oh my gosh, she's going to ask me about my money. She's going to be nosy and want to know about things that I don't want to tell her."

Short-term referrals are reported as stressful by one nurse, one social worker, and one chaplain. An example is given by the nurse where a crisis situation existed: the patient could no longer talk and was out of pain control, and the wife was in tears and angry at the physician. The nurse got the pain under control and spent three hours getting the necessary equipment into the
home. The patient died five hours later. The social worker experiences stress if she has time for only one visit and no opportunity to establish a relationship with a patient before that person's death. The chaplain states that she could be more effective if she were called in earlier rather than waiting for an emergency.

Two social workers describe the stress when a group of patients, "admits," enter the hospice program at the same time. One says that visiting the patients and writing up assessments within the 48-hour period required by Medicare is stressful.

Five nurses report that physicians create stress for them. Having a physician order aggressive treatment when it is no longer effective is a stress mentioned by one nurse. As an example, she relates an instance when a patient was in the last stages of his illness, strapped down, a "prisoner of war," and the physician ordered chemotherapy with a 2% chance that the patient would live one more month as a result. Another nurse states that hospice nurses have taken many classes on pain and symptom control of terminally-ill patients and are aware of ways to keep the patient comfortable, and some less-informed physicians are many times reluctant to prescribe the medications suggested by nurses when the patient is in extreme pain. As one nurse says, some doctors expect nurses to "keep their place." Another nurse reports that many doctors are afraid to make the "life expectancy of six months or less" statement required by Medicare to their patients and families.

One nurse tells of requesting a doctor to prescribe increased medication for a patient. The doctor said, "Well, I don't really want to up his medicine right now because we just did it a week ago, and let's give it some time." The nurse told him that a week was adequate because the patient was still screaming with pain.
Two nurses reported ways to develop a better relationship with doctors who were not sympathetic to the palliative care concept. In one hospice, some of the staff invited a "difficult doctor" out to lunch so they could understand each other better. In another hospice, the nurses invited doctors' oncology nurses to breakfast, knowing that the office nurses often find a way of helping to change doctors' attitudes.

Table 11

<table>
<thead>
<tr>
<th>Work-Related Causes of Stress Stated by Two or More Workers</th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>First visits to patient &amp; family</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Communication of hospice concept</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Faulty perception of social worker's role</td>
<td>1</td>
<td>2</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Short-term referrals</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Several admits/assessments at once</td>
<td></td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Physicians - pain control/treatment of pt.</td>
<td>5</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Ministers of patients &amp; families</td>
<td></td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Sensitivity to spiritual stances of pt./family</td>
<td></td>
<td></td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>On call</td>
<td>3</td>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Pressure of time</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Totals</td>
<td>17</td>
<td>8</td>
<td>11</td>
<td>36</td>
</tr>
</tbody>
</table>

Four of the chaplains describe their relationships with ministers of patients and families as stress-producing, though all four state that their goal is to serve as liaisons if the patient and/or family are in a parish. One chaplain reports that sometimes a patient complains that the church minister is not visiting often enough or that the patient does not want the church minister to
visit, but would like spiritual guidance. The chaplain said, "I have to tread lightly."

One chaplain remarks that his crossing of conference or denominational lines is sometimes perceived as invasion of another minister's territory. The chaplain tries to explain to the protesting minister that the chaplain is there at the request of the family and only for the purpose of bringing spiritual comfort to them. Another chaplain experiences stress when the patient and/or family's minister is a "spiritual headhunter" with a rigid approach to death and dying situations. The patient's minister may be upsetting the patient by his or her spiritual demands. He further remarks that some ministers are very uncomfortable with the death process, and tactfully making suggestions to those ministers creates stress.

Three chaplains report the stress of trying to be sensitive to the spiritual stances of patients and families. As an example, one chaplain finds stress in being careful to minister to the needs of patients and families, and not his own needs, when their beliefs are different from his. At the same time, he says he does not want to compromise his own integrity and searches for the commonality that will bring comfort to the patients and families. He further describes the stress of being very careful with his words when he is present at the patient's death, knowing that the family will remember every word because the emotional level is magnified at that time. The chaplain says that he feels responsibility for how the family may deal with the grieving process as a result of his words. Further, in conducting a funeral or memorial service where friends or family are participating in remembrances of the deceased, he reports that he has to maintain a high degree of sensitivity to what is happening from moment to moment, wanting the service to be "just right" for the comfort and support of the bereaved.
Three nurses find being on call stressful. One states that when she is tired and on call, she feels herself spread too thinly. The weekend is long, and she reports sometimes wondering if she is making the right decisions. Not knowing when the beeper will go off is mentioned by another nurse as anxiety-producing.

The pressure of time is given as a stress by four nurses, three social workers, and one chaplain. One nurse recounts her stress when two patients require a great deal of her time during a particular week, and she has difficulty finding time for her other patients as well as doing all of her paperwork. One social worker reports planning her day and then having constant interruptions during her office time with new deadlines for certain information and unforeseen requests by others for assistance. The chaplain has stress clearing his church calendar when an unanticipated need for him arises with a patient or family.

Nurses report more work-related stressors than the social workers. Part of the difference between the number of stressors reported by the two groups is: (1) nurses make evaluations before the patient is formally admitted to hospice; (2) nurses are the ones who keep in contact with the doctors; and (3) nurses are the ones who are "on call."

The table also indicates that chaplains report more stress than the social workers as they deal with the sensitive areas of spiritual care--always changing with different patients and families--and in the sensitive area of working with other ministers.

Consideration needs to be given to the fact that only six social workers are part of this study. A seventh worker would have increased the reported number of stressors by social workers.
Personal stressors, as shown in Table 12, relate to the internalization of what happens to the hospice workers as a result of working with patients and families. Three nurses, four social workers, and two chaplains express their feelings of loss when patients die or when specific patients die.

One nurse relates the feeling of loss she felt over a patient in her 40s. This woman had been very involved with her own family, the community, the area, and the church and was seen as the most dynamic woman the nurse had ever known. The patient had high values and taught all those who knew her how to live. The nurse experienced added stress at the death when family and friends were at the bedside, and the deceased had a discharge of black matter from her mouth. A social worker relates her feeling of loss when a woman her own age died, leaving a son the age of the social worker's boy.

<table>
<thead>
<tr>
<th></th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings of loss, including specific deaths</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Pain/deterioration of patient</td>
<td>3</td>
<td>2</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Funeral home/family visits</td>
<td>2</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Deaths in succession</td>
<td>1</td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Physical responses to stress</td>
<td></td>
<td></td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Totals</td>
<td>9</td>
<td>9</td>
<td>4</td>
<td>22</td>
</tr>
</tbody>
</table>

A chaplain says that for her the hardest part of hospice work is that she grows attached to a person, and the patient's death becomes like that of a neighbor. Another chaplain reports that soon after he accepted a new position as pastor, a woman in his congregation had a recurrence of cancer. He ministered to the patient and family through the rediscovery of the disease and
the patient's illness. On the night of her death at home, the chaplain was called
to assist the family in their grief. Later, he conducted the service for his
parishioner.

Three nurses and two social workers experience emotional stress over
the pain and/or deterioration of a patient. The three nurses report their stress
when the patient is not as comfortable as medically possible. The two social
workers relate stress over the physical deterioration of patients.

Two nurses and one social worker feel stressed when they make visits to
the funeral home and/or visit with the family after the death. One nurse and the
social worker state that there is stress in closing with the family. Another nurse
finds stress if there is a viewing at the funeral home because she misses the
person's smile and how the person looked when she could help him or her.

One nurse and one chaplain mention that having successive deaths of
hospice patients is stressful. The nurse reports that successive deaths are her
greatest stress. The chaplain experiences stress when two deaths happen on
the same day.

Two social workers and one chaplain describe the physical
manifestations of stress that they experience. One social worker has
headaches, and one develops a stiff neck. The chaplain, who also has hospital
duty, is subject to physical exhaustion.

Administrative causes of stress related by workers are associated with
Medicare requirements and utilization of time in team meetings as shown in
Table 13. Four nurses, three social workers, and one chaplain report stress
caused by Medicare requirements. The four nurses and two of the social
workers find all of the paperwork and time frames that Medicare requires are
stressful. One social worker finds the regulations for quality assurance to be
stressful. Two nurses mention additional stress because there is something
new required all of the time. One nurse finds it stressful to have paperwork take her away from her patients. Two nurses mention the stress of picking up and delivering medications at odd times. The chaplain observes that stress is created because the Medicare requirements "border on harassment" even though there is a need for quality control.

Table 13

<table>
<thead>
<tr>
<th>Administrative Causes of Stress Stated by Two or More Workers</th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare requirements</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Utilization of time in team meetings</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Totals</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>11</td>
</tr>
</tbody>
</table>

How the time in team meetings is used creates stress for one nurse, one social worker, and one chaplain. The nurse reports that when team meetings extend longer than the scheduled time, she finds it stressful because she has made appointments to see patients, and they expect her to be on time. The social worker speaks of stress when too much time in team meetings is taken for discussing the physical aspects of cases. The chaplain feels stress and that his time is wasted when discussions in the meetings wander inappropriately.

Workers report that the interdisciplinary team and team individuals cause stress, as shown in Table 14. Stressors are related to disagreement/power conflicts, imposed role expectations, and the need for better communication.

One nurse, two social workers, and one chaplain describe stresses caused by team disagreements and power conflicts.
The nurse has stress when she believes the team is not "on target" with the needs of a patient and family. Sometimes she feels that non-medical team members do not understand her position: the medical aspects of the case should be addressed before other kinds of support are needed or effective.

One social worker experiences stress because of her perception that the nurses regard any problems beyond physical or concrete problems as "fluff." This social worker fails to see that having a bowel movement within the last 24 hours is just as important as the patient's wife feeling really concerned about how she is going to manage after the death of her husband.

Another social worker states that she has stress when members of the different disciplines seem to be competitive: who is the most important, shares the most important information, or has the right information—instead of focusing on how to meet the patient's needs. The chaplain comments that stress for him increases if there is team disagreement about how the members of the team have dealt with the patient and family.

Table 14

Interdisciplinary Team & Team Individuals as Causes of Stress
Stated by Two or More Workers

<table>
<thead>
<tr>
<th>Cause</th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagreement/power conflicts</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Imposed role expectations</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Need for better communication</td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

One nurse, one social worker and two chaplains experience stress from imposed role expectations by other team members. The nurse tells of her stress
when the team decides that she needs to see a patient seven times a week when she already is seeing that patient four times a week and wonders where the team expects her to find the additional time.

The social worker is stressed when another member of the team says, "Oh, you can do that," when it is a difficult task that the social worker may not be able to accomplish. The social worker feels additional stress if she fails to succeed.

One chaplain finds it stressful when the team expects added time or effort on his part. He also reports stress if he or other clergy go into a patient's home, and later hear through the nurse or social worker that the patient or family did not find the visit satisfactory. Whether it is the chaplain or other clergy who has not met the needs of the patient or family, the chaplain feels much responsibility.

Another chaplain, who states that he is unpaid, finds it stressful when the team expects him to give hospice priority over his church.

One nurse and one social worker report that the need for better communication causes them stress. The nurse says that the rapid growth of the agency, role changes of some of the staff, and the addition of new workers cause some breakdowns in communication. The social worker is stressed when a nurse seems to be always in a hurry and does not take the time to discuss a case about which the social worker needs information. A stressful situation is reported by a social worker when she finds that her remarks are misconstrued by another member of the interdisciplinary team.

**Coping with Stress**

Ways that hospice workers cope with stress are divided for purposes of this study into five groups as shown in Table 15: (1) adaptive physical responses; (2) adaptive cognitive and emotional responses; (3) socially
adaptive responses; (4) administrative responses, and (5) interdisciplinary
team/team individual responses.

| Summary of Ways of Coping with Stress Stated by Two or More Workers |
|-----------------------|----------------|----------------|-----|
|                       | Nurses | Social Workers | Chaplains | Total |
| Adaptive Physical Responses | 10     | 5              | 7          | 22    |
| Adaptv. Cognitive/Emotional Responses | 9      | 15             | 9          | 33    |
| Socially adaptive responses   | 7      | 5              | 3          | 15    |
| Administrative Responses       | 7      | 3              | 7          | 17    |
| Interdisciplinary team/team individuals | 17     | 10             | 10         | 37    |
| Totals                     | 50     | 38             | 36         | 124   |

Adaptive physical responses as defined here are activities that are totally apart from the hospice setting and are shown in Table 16.

Five nurses, two social workers, and four chaplains mention physical activities such as racquetball, walking, jogging, camping, hunting and fishing. One of the chaplains said that his way of coping with stress depends upon the season of the year. In summer he fishes and really does not care if he catches anything. In the fall he hunts and does not care if he finds any game. During the winter he pursues his hobby of making figures by welding them from coat hangers. In the spring he takes his boat out on a river. He stated that he learned his lesson about coping with stress when he had three-fourths of his stomach removed for ulcers.

One nurse plays football with her sons. She remarks that if she were a hospice patient, she would not want to talk about plants or sewing; she would find much more pleasure in talking of sports. She says that hospice volunteers should be cognizant of the patient's interests and hobbies.
Four nurses, one social worker, and two chaplains find release from stress through music, reading, and various hobbies. One of the nurses plays the violin and is a member of a quartet, an orchestra and a music club. She and her husband--and/or other members of the family--attend plays and concerts.

A social worker and a chaplain find that their pets are great stress reducers. One chaplain bought a long-coated Chihauhau for his wife when their children started leaving home, but says that the dog is as much a stress-reliever for him as it is for his wife. No matter how many people "have been on his back" that day, he can come home, pick up the newspaper, and have the dog jump in his lap and try to kiss him. It makes the chaplain feel that someone likes him.

One nurse and one social worker mention that using relaxation techniques helps them cope with stress. They sit quietly and use imagery to relax.

---

<table>
<thead>
<tr>
<th></th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical activities</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Hobbies, music, reading</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Relaxation techniques</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Pets</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>11</td>
<td>5</td>
<td>6</td>
<td>22</td>
</tr>
</tbody>
</table>
Adaptive cognitive and emotional responses, shown in Table 17, are concerned with restructuring the way one examines one's inner self and deals with stress so that relief is obtained.

Philosophical and/or religious orientations reduce stress as indicated by one nurse, three social workers, and three chaplains. One nurse reduces her stress by remembering a special experience with a dying patient she stayed with before she became a hospice worker. The patient's wife had died two years previously, and he saw her holding out her arms to him. He told her that he needed two more days before joining her. The nurse felt a draft enter the room, bringing a peaceful feeling that to her was Death and Christ. She and the patient were aware of an odor of flowers permeating the room. The patient told the "Presence" that he wanted two more days. The nurse reported that visitors during the next two days could not smell the flower odor, although she and the patient still could. When the patient asked about his son, the nurse reminded him that he had seen his son the preceding day and that the son would be playing in a dance band that evening. The patient said that he and his wife would be dancing to the son's music, told the nurse good-by, and died.

One of the social workers copes with her stress by re-reading or thinking about Harold Kushner's book When Bad Things Happen to Good People. One chaplain finds her stress reduced through "gifts of God."

One social worker and three chaplains use such methods as meditation, prayer, and time alone for stress reduction. One social worker consistently spends two days a month at a retreat center and allows nothing to interfere with this schedule.

Two nurses and one social worker state that the satisfaction they receive from their hospice work reduces their stress. One nurse reports that she gains a great deal when she observes a hospice family's closeness and how they pull
together and support each other. Seeing patients in comfortable surroundings and doing the things that they want to be doing and feeling that she is helping them live the best they possibly can reduces her stress. The social worker says that she always receives more than she can ever give, and the opportunity to learn from hospice patients and families helps her cope with her stress.

Table 17
Adaptive Cognitive & Emotional Responses as Ways of Coping with Stress Stated by Two or More Workers

<table>
<thead>
<tr>
<th></th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philosophical/religious</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>orientation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditation, prayer, retreat,</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>time alone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction of helping</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>families</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dealing with grief when it</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>happens</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crying</td>
<td>2</td>
<td>2</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Self-talk</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Making lists, prioritizing</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>work</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>9</td>
<td>15</td>
<td>9</td>
<td>33</td>
</tr>
</tbody>
</table>

Two nurses report their stress is reduced when they deal with grief as it happens and do not let it build up. Two nurses and two social workers find that crying reduces their stress. One of the nurses turns up the radio and cries as she drives in her car when the number of deaths are building up, then goes home and relaxes in a hot bath while listening to music.

One nurse, four social workers, and two chaplains use self-talk. For example, one nurse states that when she is under stress and feels out of control, she sits back and says, "Okay. This is what I am going through. This is what I am going to do to be back in control." One social worker talks to herself
and says that if there is nothing she can change, she will not hold on to the stress. One chaplain says that she has learned to tell herself to let go when everything does not go according to schedule and thus reduces her stress.

Two social workers cope with stress by making lists and prioritizing their work. They say that this keeps them from being frustrated over trying to do everything at the same time.

Socially adaptive responses, as shown in Table 18, involve people outside the hospice staff. Three nurses, three social workers, and one chaplain cope with stress by talking to their spouses or significant others. One nurse says that her husband is a good listener. When a hospice death has occurred, he comforts her and helps her through it. Two nurses, one social worker, and two chaplains find that their stress is reduced when they visit with friends or others whom they know. One chaplain finds relief from stress when he talks things over with his church staff.

<table>
<thead>
<tr>
<th>Socially Adaptive Responses as Ways of Coping with Stress</th>
<th>Stated by Two or More Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking with spouse or signif. other</td>
<td>Nurses: 3</td>
</tr>
<tr>
<td>Talking with friends/others</td>
<td>Nurses: 2</td>
</tr>
<tr>
<td>Family activities</td>
<td>Nurses: 2</td>
</tr>
<tr>
<td>Totals</td>
<td>Nurses: 7</td>
</tr>
</tbody>
</table>

Two nurses and one social worker report that participation in family activities reduces their stress. One nurse shares in the interest her family has in showing horses. The nurse enjoys the shows, likes working with the horses and even cleaning up the barn. Her remark is, "At least you can pitch it!"
One social worker says that talking with her husband is her best method of coping with stress. She looks forward to going home and playing with the children--taking walks and sharing in games. She reports that it is easy for her to forget about what she does all day when she is with her family.

Several of the respondents report administrative assistance in stress reduction, as shown in Table 19. Two nurses, one social worker, and two chaplains mention bonding activities such as birthday celebrations, secret pals, and parties. Three nurses and two chaplains experience stress reduction in the retreats and clinics planned by the administration.

<table>
<thead>
<tr>
<th>Bonding activities, celebrations</th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retreats and clinics</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Supportive director or coordinator</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Support groups/special assistance</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>7</td>
<td>3</td>
<td>7</td>
<td>17</td>
</tr>
</tbody>
</table>

One nurse tells of two staff retreats that took place from Saturday morning to late Sunday afternoon at a "nice retreat place." A person from California talked to the staff about Transcendental Meditation, and the staff was introduced to new concepts. Another time a nun who travels across the nation spoke on humor.

Another nurse reports that on their all-day staff retreat days twice a year an agenda is written up. The group usually begins with social interaction over coffee. She says that somewhere in the day they share with others what they
appreciate about them. Time is not always available for that during workdays. At the retreat sometimes it takes two hours for everyone to go around and say affirming things to each person. During the day they set goals for the group—the direction in which they plan to go for the next six months. One time the goal was to improve bereavement services; another time it focused on setting standards of care.

Two social workers and two chaplains state that understanding hospice directors or coordinators are helpful in stress reduction. Two nurses and one chaplain mention that their stress is reduced through support groups and/or counseling assistance provided to them.

**Team Approach and Stress Reduction**

The interdisciplinary team is effective in stress reduction according to interviews with hospice workers. Ways the team or team individuals help reduce stress are shown in Table 20. Six nurses, two social workers, and four chaplains state that having input on problems reduces their stress.

One nurse says that her stress is decreased when the team gives suggestions for problems she feels she cannot and does not want to solve by herself. She appreciates any reminders if she has overlooked some things. The team helps her work through ideas, and together they try to find solutions. One social worker states that when she feels that she is "in a rut" in working on a patient and/or family problem, the team is a sounding board and tells her if she is "off base"—or gives her suggestions—and that relieves her stress.

Another nurse states that the team is very sensitive and understanding. The nurse had just returned from an out-of-town meeting to find that a year-long patient died while the nurse was gone. The nurse burst into tears and was
given comfort by the staff. Also, she says that when she is struggling with how
better to serve a family or patient, she can talk comfortably with any member of
the team and ask for assistance.

One chaplain says that his stress is reduced when more people are
working on a problem, and they offer additional insights and assistance. This
chaplain gives an example of this process. A nurse is wondering why the
patient will not take pain medication; the chaplain suggests that the patient may
be thinking that suffering expiates sins.

Table 20
Interdisciplinary Team/Team Individuals as Ways of Coping with Stress
Stated by Two or More Workers

<table>
<thead>
<tr>
<th></th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Input on problems</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Ventilation of stresses/feelings</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Support</td>
<td>5</td>
<td>3</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Sense of teamwork and respect</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Totals</td>
<td>17</td>
<td>10</td>
<td>10</td>
<td>37</td>
</tr>
</tbody>
</table>

Five nurses, four social workers, and one chaplain report that the
opportunity to ventilate their feelings reduces their stress. One nurse states that
her stress is decreased because when she shares how she feels, she finds out
that others feel the same way, and that she is not alone in the situation. She
tells of being "mad at God" for making a 22-year-old patient sick with AIDS, and
that she cannot do anything about it. Knowing that other people feel the same
way, she does not have to feel bad because of her anger that this is happening
to a young person who should be starting his life, not ending it.
One social worker says that because team members can listen to her and she can vent whatever frustration she is having, her stress level is decreased. The chaplain states that his stress is reduced because he can be open with other team members, and that they can be open with him.

The support given by the team reduces the stress of five nurses and three social workers. One nurse says that when she is having a difficult time, someone on the team is always there to listen, to encourage, and to support her. She goes on to say that the tremendous amount of support she derives from the team greatly reduces her stress. One of the social workers reports that the team lessens her stress by giving her support in a way that she believes would not be found in the ordinary business place. If she needs affirmation or emotional support, team members are there to give it.

The sense of teamwork and respect for each other's profession are stated by one nurse, one social worker, and five chaplains as reducing stress. One nurse remarks that teamwork relieves her of the feeling of having the total responsibility for a patient and family, and when she reminds herself that she does not have to feel that she is carrying the whole load, her stress is lessened. The social worker reports stress reduction by knowing that she is part of a team with a unified goal. One chaplain states that his stress is decreased by the sense of teamwork he experiences; he has never worked with a better group of people and feels rewarded to be with them. They are all directing their activities and energies in the same direction.

The respondents' perceptions of their own importance to the interdisciplinary team or essentiality to the team (integrality) and their perceptions of other team members' integrality are shown in Table 21.
Table 21

Integrity Perceptions of Respondents

<table>
<thead>
<tr>
<th></th>
<th>(0) Not at all</th>
<th>(1) Slightly</th>
<th>(2) Moderately</th>
<th>(3) Very Significantly</th>
<th>(4) Totally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses by nurses</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses by social workers</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses by chaplains</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Workers by social workers</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Workers by nurses</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Workers by chaplains</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chaplains by chaplains</td>
<td>1</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chaplains by nurses</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chaplains by social workers</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The integrality perceptions of the hospice workers as a group, shown in Table 22, yield a mean of 3.1 on a scale of 0-4, with 0 indicating Not at All and 4 indicating Totally. The range of the responses is 2-4. On the same scale, the nurses' perceptions of their own integrality have a mean of 3.4 and a range of responses of 3-4. The nurses' perceptions of the social workers' integrality has a mean of 3.2 with a response range of 2-4. The nurses' perceptions of the chaplains' integrality have a mean of 3.0 with a response range of 2-4.

On the same scale, the social workers' perceptions of their own integrality have a mean of 3.0 with a response range of 2-4. The social workers' perceptions of the nurses' integrality has a mean of 3.5 and a range of responses of 3-4. The social workers' perceptions of the chaplains' team integrality have a mean of 2.0 with all of the responses in the 2 category.

On the same scale, the chaplains' perceptions of their own team integrality yields a mean of 2.9 with a response range of 2-3. The chaplains' perceptions of the nurses' integrality have a mean of 3.4 with a range of 3-4.
The chaplains' perceptions of the social workers' integrality have a mean of 3.2 and a response range of 2-4.

Table 22
Perceptions of Integrality by Respondents

<table>
<thead>
<tr>
<th>Perceptions by</th>
<th>By Nurses</th>
<th>By Social Workers</th>
<th>By Chaplains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>3.4 R*3-4</td>
<td>3.5 R 3-4</td>
<td>3.4 R 3-4</td>
</tr>
<tr>
<td>Social workers</td>
<td>3.2 R2-4</td>
<td>3.0 R 2-4</td>
<td>3.2 R 2-4</td>
</tr>
<tr>
<td>Chaplains</td>
<td>3.0 R2-4</td>
<td>2.0 R 2-2</td>
<td>2.9 R 2-3</td>
</tr>
</tbody>
</table>

*Range of responses

Mean of Perceptions
Mean of All Workers 3.1
Range 2-4

The respondents' perceptions of their decrease and increase of stress related to the team approach are reported, as shown in Table 23. The interdisciplinary team decreases stress of all the workers by a mean of 2.3 on a 0-4 scale, with 0 indicating No decrease and 4 indicating Very great decrease. The respondents' range falls between 0-4.

The interdisciplinary team decreases nurses' stress by a mean of 2.9 on the same scale with a range of 1-4. The interdisciplinary team decreases social workers' stress by a mean of 2.0 with a response range of 0-4. The interdisciplinary team decreases chaplains' stress by a mean of 1.9 with a response range of 0-3.

Hospice workers' perceptions indicate that the interdisciplinary team increases their stress by a mean of 1.1 on a 0-4 scale, with 0 indicating No Increase and 4 indicating Very Great Increase. The respondents' range falls between 0-3.
The nurses perceive the interdisciplinary team as increasing stress by a mean of 1.0 on the same scale, with a response range of 0-2. The social workers' perceptions of increase in stress by the interdisciplinary team have a mean of 1.3, with a range of 0-3. The interdisciplinary team increases chaplains' stress by a mean of 1.1. The responses range from 0-2.

<table>
<thead>
<tr>
<th>Decrease in stress</th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0) No decrease</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(1) Slight decrease</td>
<td>1</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>(2) Moderate decrease</td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>(3) Great decrease</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Mean of decrease</td>
<td>2.9</td>
<td>2.0</td>
<td>1.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Increase in stress</th>
<th>Nurses</th>
<th>Social Workers</th>
<th>Chaplains</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0) No increase</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>(1) Slight increase</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>(2) Moderate increase</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>(3) Great increase</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mean of increase</td>
<td>1.0</td>
<td>1.3</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Mean of decrease of all groups 2.3
Mean of increase of all groups 1.1
In summary, similar stresses are reported by nurses, social workers, and chaplains. In addition, each professional group has its own. The perceptions of the interviewed nurses, social workers, and chaplains indicate that the interdisciplinary team reduces stress to a greater degree than it causes stress.
CHAPTER 5
Conclusions and Recommendations

This study is designed to determine the relationship between the interdisciplinary team approach and stress reduction among hospice workers. Related literature and field research in Iowa hospices are examined, conclusions drawn, and recommendations made.

As indicated earlier in this study, hospice began as an alternative to hospitalization for the terminally ill. The focus is on the patient and family rather than on hospital regimentation. The patient is cared for in the patient's home, in a specially designated section of an acute or long-term care facility, or in a freestanding facility. The emphasis is on palliative care when aggressive treatment is no longer appropriate. Pain control and quality of life are primary objectives of hospice.

The literature evidences that hospice workers are subject to many stresses which can lead to burnout. Often part of the everyday life of the hospice worker are the emotional impact of constantly dealing with death, the facing of patient and family problems, administrative frustrations, professional challenges, the worker's own personal problems, and interdisciplinary team difficulties. Methods of coping, also discussed, include the understanding and mutual assistance of interdisciplinary team members.

Interdisciplinary teams are required for Medicare-certified hospices. Between November 16-24, 1987, the researcher conducted semi-structured
interviews with a nurse, a social worker* and a chaplain at each of the Medicare-certified hospice sites in Iowa.** The purpose was to further understand the relationship between the team approach and stress reduction of hospice workers. The results of the research findings are presented in the preceding chapter and include an examination of: (1) characteristics of hospice workers; (2) stress among hospice workers; (3) coping with stress; and (4) team approach and stress reduction.

**Characteristics of Hospice Workers**

The respondents have a significant age difference by profession. The social workers are the youngest, and the chaplains are the oldest. As the first hospice in Iowa became Medicare-certified in November 1983 (Hospice of Central Iowa), Medicare's requirement of a social worker might be the reason that social workers are the youngest professional group. Nurses helped begin hospices before Medicare guidelines were established. Reasons for the older age of the chaplains might be that (1) educational requirements for most ministers take longer to complete than for the other two professional groups, and (2) they appear to have more years of life experience, e.g., the three female renunciant chaplains who served in other areas before they became chaplains.

In length of service, the means of the nurses (38.7 mos.) and the chaplains (39.4 mos.) are less than a month apart. The mean of the social workers (22.3) is significantly lower; four have served a year or less. The social workers may come into hospice with a lack of understanding of the nature of the work and leave for a different type of employment as Vachon (1986c) suggests.

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* One social worker was not interviewed as she had been employed only five days.
** Hospice of Central Iowa was not included as the writer interned there.
Again, the recent Medicare-certification of some of the hospices may account for openings which had not occurred previously.

As reported in the preceding chapter, only three of the twenty interviewees are full-time hospice workers. The writer believes, as a study by Masterson-Allen, Mor, Laliberte and Monteiro (1985) shows, that staff who work on a full-time basis in direct contact with patients are more prone to burnout. Some of the respondents work part-time in other capacities, and they report that curative or restorative cases provide a balance. For full-time hospice workers, keeping stress at a manageable level is very important, and hospice workers and administrators must give this more attention. This is supported by the literature.

**Stress Among Hospice Workers**

In giving their perceptions of the amount of stress experienced on an average day, with 0 indicating no stress and 4 indicating very great stress, the social workers had the highest level of stress (mean of 2.0) and the chaplains had the least (mean of 1.4). The nurses had a mean of 1.7. The reasons for this may be that the nurses accept death as part of their profession, and also, as a group, they are older than the social workers. The chaplains have had more life experience than either the nurses or the social workers and work fewer hours in hospice.

The social workers not only have the highest stress on an average day, they have the highest stress on a tense day with a mean of 3.3. The chaplains have the next highest mean (3.1), and the nurses have the lowest (3.0). As reported in the findings, chaplains find it very stressful when they want to offer the spiritual comfort that is helpful to the particular patient and family at the deathbed of the patient. This may account for the higher mean of the chaplains.
on a tense day. It should also be noted, however, that the social workers are .2 higher than the other two professions and that only a difference of .1 exists between the mean of the chaplains' stress and the mean of the nurses' stress.

The range of the last tense day for the nurses extends from "Yesterday to 6 months." The range for the social workers is smaller, 2 days to 1 month. This is another indication that the perceptions of stress by the social workers are more than that of the nurses. The range of the chaplains is "Last week to 1 month."

Of the 22 personal stressors named, the nurses and social workers are responsible for the same number, 9. The chaplains named 4, less than half as many as the nurses and social workers. One reason for this may be that only 6 social workers were interviewed. Also, the chaplains may be more attuned to and trained in the areas of death and feelings of loss because of the spiritual nature of their work.

Coping with Stress

As discussed in both the literature and findings, hospice workers need to cope with their stresses if they are to avoid burnout. Methods of coping include physical activities, such as sports, hobbies, and relaxation techniques. Adaptive cognitive and emotional responses mentioned are meditation, self-talk, dealing with deaths as they happen, and the satisfaction of helping people. Socially adaptive responses given are talking with the worker's spouse or others and family activities. The writer concurs with the importance of maintaining a balanced life as a way of reducing stress. Each person needs to determine the most effective ways of coping for himself or herself. Administrators need to provide assistance for reduction of stress of hospice workers.
Team Approach and Stress Reduction

According to the literature and the field research, interdisciplinary teams reduce the stress of its members by supporting each worker, trusting each other, giving input on patient and family problems, sharing responsibility for the outcomes, and affording a place to ventilate the stresses each member feels. A team functions most effectively when each member feels, and is regarded as, an equal.

The nurses and the chaplains perceive the integrality of the nurses in the interdisciplinary team in the same way--3.4 on a scale where 0 indicates Not at All, and 4 indicates Totally. The social workers rate the nurses at 3.5, slightly higher on the scale. The social workers, on the same scale, rate their interdisciplinary team integrality at 3.0, whereas both the nurses and the chaplains rate their integrality at 3.2, resulting in a 0.2 difference. The social workers perceive the nurses higher and themselves lower; the nurses and chaplains agree in their ratings of the nurses and social workers.

The chaplains and the nurses essentially are in accord concerning the integrality of the chaplains in the interdisciplinary team. The chaplains give themselves a 2.9 rating, and the nurses rate them at 3.0, one-tenth of a point higher. The social workers give the chaplains a 2.0 integrality rating. Two social workers specifically comment that their "Moderate" evaluation for the chaplain's integrality is because some patients have their own clergy. These two social workers and other social workers implied that the "Moderate" rating was because the chaplains have fewer hours with hospice and, therefore, are not as involved with the team.

The assumption in this study is that participation in an interdisciplinary team reduces stress and lessens burnout of the hospice worker. As indicated in
the previous chapter, the respondents find that the interdisciplinary team decreases their stress more than it increases their stress. The scale used is 0 for No decrease and 4 for Very great decrease; 0 for No increase and 4 for Very great increase. The nurses find that the team approach reduces their stress by a mean of 2.9 and increases stress by a mean of 1.0. This 1.9 difference is the greatest found among the professional groups.

The social workers show a 2.0 mean decrease of stress with the team approach and a 1.3 mean increase, making the stress reduction mean 0.7 greater than the increase mean. The chaplains have a decrease mean of 1.9 and an increase mean of 1.1, giving them a stress reduction mean of 0.8 greater than the increase mean.

These findings from the field research support the literature. Although the interdisciplinary team may increase stress to a degree, it reduces stress to a greater degree. On the scale previously given, the perceptions of stress decrease related to the team approach for all groups has a mean of 2.3. The perceptions of stress increase related to the team approach for all groups has a mean of 1.1, making the stress reduction mean 1.2 greater than the increase mean.

The literature and the field research indicate the validity of the assumption on which this study is based. Participation in an interdisciplinary team reduces stress and lessens burnout of the hospice worker.

**Recommendations**

From the interviews and readings, this researcher suggests that hospices might consider, if they have not already, the following suggestions.

For a more effective interdisciplinary team, trust and cooperation should be nurtured constantly. This is not to say everyone must agree, but different
viewpoints can be examined constructively with respect for their proponents and resolved in the best interests of the patients and families. When interdisciplinary teamwork is strengthened, stress is reduced. An example of a tool to help accomplish this is given in the Appendix C, *Focus on the Patient*, a manual submitted for publication to the National Hospice Organization. Written by Dr. John H. Cooper of George Mason University and this writer, the manual is designed to enhance interpersonal skills of participants, increase understanding of professional roles, provide an avenue for discussion of patient and family issues, and develop teamwork.

Of the seven hospices visited by the researcher, one in particular seems to have an especially harmonious interdisciplinary team. The director chooses professional workers not only for their ability and skills, but also for their potential for positive interpersonal relationships. New workers are made aware of the expected norms of team membership and specifically are encouraged to be caring of, and open with, other members of the staff. The writer believes that this procedure would benefit all hospices.

Interdisciplinary meetings are one of the stresses listed by hospice workers. The writer is of the opinion that some of the following patterns suggested or used by respondents merit consideration:

1. Send out prepared schedules two or three days before team meetings. Encourage volunteers and family ministers to be in attendance at the interdisciplinary team meetings at the specific times their patients are scheduled. These persons do not sit in on discussions of other patients. Meeting together facilitates communication, provides greater input, eliminates smaller team meetings, and saves time.

2. Arrange the meeting schedule so that those persons needed to discuss only a few cases may leave to continue their duties elsewhere.
(3) Except for unusual circumstances or new referrals, discuss half of the patient list one week and the other half the next week.

(4) Because on-call nurses update the on-call book and each other as well as some of the other staff, medical reports during the interdisciplinary meetings should be limited to those patients who need special team attention.

(5) Understand the importance of the psychosocial aspects of a case.

(6) Give concise reports. As one respondent said, "Competition as to who can say the most about a patient should be eliminated."

(7) Remember that the purpose of the meeting is to benefit patients and families.

As mentioned in the literature and the findings, the social worker is dealing with intangibles that cannot be measured in the way physical conditions can be measured. Unlike the social worker's role, those of the nurse and the chaplain are more easily understood by both the team and the family unit. The social worker's role has to be explained by the person who makes the referral visit, the nurse, or by the social worker who has to "sell" herself or himself to the patient and family. The feeling may prevail that the nurse is indispensable, and the social worker is not. The writer strongly supports a brochure similar to the one published by Hospice of Cerro Gordo that explains the social worker's role to the patient and family. Excerpts follow:

**Social Work Services**

The hospice social workers meet with each patient and family to assess how hospice can provide more complete care for the family unit.

The social workers are part of the Interdisciplinary Team. They are an additional link in the communication system which includes the physician, nurse, clergy, and other support staff.
Some ways in which the social workers may assist are:
- Advocacy
- Crisis intervention
- Arrangement of appointments
- Referrals to community agencies
- Educational instruction
- Consultation
- Follow-up

Counseling Services
Social workers are available to help you understand and deal with issues, including:
- Depression and anxiety
- Grief and loss
- Financial concerns
- Civil legal assistance (Insurance, Wills, etc.)
- Facilitation of respite or long term nursing home placement
- Adjustments to the physical, psychological and social aspects of the illness.

Curricula in appropriate professional institutions are recommended for the emotional confrontation with one's own mortality and the enablement of more effective ways to deal constructively with the terminally ill. The writer concurs with Lev (1986) that a combination didactic and clinical course is effective.

The writer believes that the hospice philosophy of having the patient and family in control constantly should be emphasized. The needs being met should not be those of the hospice worker, but those of the patient and family. The temptation to place the worker's values on recipients of hospice services must consistently be avoided and should be monitored carefully by the hospice unit.

The hospice literature search conducted by this writer did not reveal a particular stress reported by four chaplains during the interviews--dealing with the ministers of the patients and families. Research in this area, or making available research that may have been done, is recommended.
The conclusion is made that all hospices would benefit from developing interdisciplinary teams, with each member being considered an integral part of the team. Stress reduction of team members and increased quality of service to patients and family would result. Further research might examine ways of promoting full integrality for all members of the interdisciplinary team, and methods for keeping stress of team members at manageable levels.
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APPENDIXES
APPENDIX A

MEDICARE-CERTIFIED HOSPICES IN IOWA
AS OF NOVEMBER 1987
MEDICARE-CERTIFIED HOSPICES IN IOWA
AS OF NOVEMBER 1987

1. Americare Home Health Services
   Doing business as Hospice of Siouxland
   500 - 11th St.
   Sioux City 51105

2. Cedar Valley Hospice
   Kimball & Ridgeway Drive
   Waterloo 50702

3. Holy Family Hospice
   Holy Family Hospital
   816 N. 8th St.
   Estherville 51334

4. Hospice of Central Iowa
   3609-I/2 Douglas Ave.
   Des Moines 50310

5. Hospice of Cerro Gordo
   810-12th St. N.W.
   Mason City 50401

6. Iowa City Hospice, Inc.
   500 Market St.
   Iowa City 52240

7. Iowa River Hospice, Inc.
   3 South 4th Ave.
   P.O. Box 981
   Marshalltown 50158

8. Mercy Hospice
   Mercy Hospital Medical Center
   6th & University
   Des Moines 50314
APPENDIX B

WORKSHEET
WORKSHEET

Date_________________________ Sex_____ 
Hospice_________________________ Age E/L____________ 
Name_________________________ Religious Affiliation ______________ 
Role_________________________ Length Service____________________

How & why hospice work?

Educational background:

Work Schedule:

Sick leave policy:

Marital Status_____________ Family:

Family’s feelings about work:

Card #1 On the card I have given you with the question and designations, what is your perception of the amount of stress you experience day to day?

No stress  Slight stress  Moderate stress  Great stress  Very great stress

Card #1 On the card I have given you with the question and designations, what is your perception of the amount of stress you experience on tense days?

No stress  Slight stress  Moderate stress  Great stress  Very great stress

When was your last tense day?

What do you perceive to be sources of your stress?

How do you deal/cope with stress?
Card #2  On the card I have given you with the question and designations, what is your perception of being an integral part of the interdisciplinary team? Importance to/involvement in?

Worker:  Not at all  Slightly  Moderately  Quite significantly  Totally
Nurse:  
Chaplain:  
Social Worker  

How often does the team meet?

Is the meeting formal?

If so, are there informal meetings?

Are there informal ways of accomplishing the work?

Card #3  On the card I have given you with the question and designations, how does the interdisciplinary team, collectively and individually, affect your stress?

-- Increases the level of stress
-- Decreases the level of stress
-- Both increases and decreases the level of stress
-- Neither increases nor decreases the level of stress

Card #4  For decrease or increase or both. On the card I have given you with the question and designations, what is your perception of the degree the IDT increases/decreases stress?

___ No decrease  ___ No increase
___ Slight decrease  ___ Slight increase
___ Moderate decrease  ___ Moderate increase
___ Great decrease  ___ Great increase
___ Very great decrease  ___ Very great increase

Under what circumstances does the interdisciplinary team decrease stress?
APPENDIX C

FOCUS ON THE PATIENT: DEVELOPING TEAMWORK IN THE HOSPICE SETTING
FOCUS ON THE PATIENT

Developing Teamwork in the Hospice Setting

By

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March 1987
ACKNOWLEDGEMENTS

The authors wish to express appreciation to Rosemary Hillman, Hospice Consultant, and those staff members of the Hospice of Central Iowa, Hospice of Montgomery County, Maryland, and Hospice of Northern Virginia who so willingly shared their professional insight and experience with us.
It is well known that hospice workers are subjected to constant crisis situations and repeated emotional stimulation. Hospice team members are thus prime targets for occupational stress because their everyday work situations are associated with patients and families experiencing a high level of psychic and physical pain. Developing a sense of teamwork and cooperation can reduce the reality of stress which is a daily concern of hospice professional and volunteer staff members.

In order to perform hospice work effectively, the team members must have an understanding of the blending of professional roles. The team members must develop trusting relationships with others on the team. A comfortable, supportive, collaborative work environment should prevail.

This training manual provides team exercises that will direct discussion toward effective problem solving. The hospice team participants will be provided opportunities to identify creative options and to verbalize feelings as well as opinions. This manual guides the hospice team to focus on psychosocial-spiritual needs of hospice patients and their family members. Tackling the tough patient-family problems in hypothetical situations is likely to make the team feel that the actual patient difficulties they encounter are more manageable.
Hospice programs must direct attention to nurturing the hospice staff as a prerequisite to providing quality care for the hospice patient-family. It would be of great benefit to all hospice teams to have an opportunity to use this manual.

Rosemary Hillman, Hospice Consultant
Board Member, National Hospice Organization
INTRODUCTION

As attention is directed toward prevention of disease and promotion of health and well-being, emphasis on the quality of life throughout the life cycle is increasingly being accepted as the goal to be sought by healthcare providers and consumers alike. This changing or expanding emphasis has resulted in recognizing that the traditional healthcare training model, while appropriate for treatment of illness, must be augmented or replaced in many settings by a more holistic approach. Illustrating the need for this change in emphasis is hospice. As a concept and program, hospice is designed as a caring system in which the patient and family are the focus. Its objectives are to achieve the highest quality of living possible for the dying person and to allow the patient and family to be in control of all choices and decisions concerning care and services. The hospice movement in the United States has resulted in a work setting quite different from the usual or accepted settings for which most helping professionals have been prepared. As Jessie L. Steinfeld, M.D., states:

The education of the health professional does not prepare him to cope adequately either with the needs of the dying patient, the needs of the patient family, or even his own reactions to the death of his patient. (1)

Consequently, assembling the hospice team will result in bringing together a group of professionals and volunteers who may have had little formal preparation and generally limited experience in providing care for the dying. For example, nursing in other work settings will, at best, provide limited opportunities for applying palliative rather than curative approaches in patient
care. The same circumstances exist for the physician, social worker, counselor, psychologist, spiritual director and volunteers. All come to the hospice arena with a need to establish personal and professional purposes and objectives which accommodate the reality of loss rather than the promise of cure—with job satisfaction and success measured in ways other than saving lives.

The need for carefully selecting and training hospice staff is of paramount importance in building the interdisciplinary team approach to caring for the patient and family. In the preparation and experience of the physician, nurse, social worker, spiritual director and psychologist, there is an identity developed with the respective disciplines. When professionals from these fields come together in the hospice setting, the interdisciplinary team must be developed. As Judy Donovan writes:

... a team does not exist simply because it is so named. ... team members who perceive other members as having similar interests, knowledge and goals often face conflict in line of duty. (2)

It is understandable that roles on the hospice team may have considerable overlap, requiring special attention to interaction among team members to anticipate and clarity all aspects of potential role conflict. A. C. Blues suggests that:

... the difference between hospice teams and other health care teams is the [hospice team] has no clear-cut hierarchy for decision making. In the hospice setting, therefore, leadership roles and allocation of tasks depend on the needs of the patient and the family as well as the skills of the team members, regardless of professional training. (3)

The need to respond appropriately and promptly to patient or family needs in the hospice context demands an overlapping of knowledge and skills by all team members. Furthermore, communication of such responses to others on the team will build cohesion and trust while ensuring follow-up as may be indicated by other team members. This blending of roles will enable the team to
focus on patient care as the primary goal of the hospice. As Beth Ellis is quoted in *Hospice Team Roles*:

We're convinced that the philosophy under which Hospice of the Valley operates—a team of professional people grounded in a common philosophy of care, reaching out to the patient together, can fulfill the emotional and social needs of all those for whom we care. (4)

Since achieving teamwork is an ongoing process, Rosemary Yancik concluded, as a result of her study on coping with hospice stress, that the special nature of hospice work requires a structured form of interaction among workers who perform similar functions. (5) Thus, implementation of the psychosocial model in which the focus is on palliative care and services will be enhanced by a planned integration of all team members' roles and responsibilities. This may be accomplished through involving all professionals and volunteers in addressing and resolving issues and problems concerning family relationships, patient stress, depression, and spiritual needs. To facilitate this process, an experientially-based framework has been developed through which members of the hospice team can "seek the common ground" which will enable each to contribute most appropriately to the care and services needed by patients and families.

To enhance opportunities for learning and understanding roles, identifying common concerns and engaging in nonconfrontational interaction, the use of case examples may be useful. From scholars and practitioners who have studied and faced the challenge of molding cooperative working relationships, a number of quotations have been selected to highlight issues, stimulate thinking and promote discussion. And finally, perceptions of hospice roles and functions from the patient's point of view provide insights which reflect consumer needs in the care-providing process. These approaches, which recognize the need for communication, anticipation of needs and coordination
of team effort, can facilitate "before the fact" problem discussion, clarification of roles, and development of strategies for dealing with those aspects of patient/family care and service which may have potential for conflict.

This manual consists of three sections: (1) synopses of actual cases, with names and details changed to protect individuals and families, (2) quotations from hospice professionals, and (3) comments of hospice patients. Each section contains discussion questions or quotations which may be used to stimulate interaction and provide a focus for the participants. With skilled leadership, the exercises can be effectively used with large staff groups, four to five team members, or even smaller units. For example, training of new staff members and volunteers could be facilitated by discussion of roles and responsibilities which can be a helpful technique in gaining insight into each team member's responsibilities.

Using the questions provided will generate initial discussion, and the open-ended synopses, quotations, and comments will leave the direction of the interaction to the facilitator and group. One of the benefits of this technique is the opportunity to bring up points of potential conflict in a nonconfrontational way. The facilitator and group members may effectively bring in parallels to current cases and thus contribute to working through problems in a cooperative effort where the focus can be on the exercise and not on the participants. The exchange of roles, interaction on all aspects of the exercises, and clarification of issues all contribute to building the team concept and, in turn, strengthening respect for each team member's contribution.
SECTION 1

SYNOPSIS

NO. 1 - NANCY

Nancy is a seventy-year-old patient with oat-cell lung cancer involving heart muscle. She has been married to her second husband, Ken, for thirty years. He is a few years younger than Nancy. Nancy's former husband, the father of Nancy's only child, Ellen, died in a car accident last year. Ellen is married and has two grown children living in the same city. Nancy was an only child, and her parents are dead.

Nancy says she "can't get a grip on herself" and that she cries continually. She doesn't want to see her friends and just wants to pull down the shades, darken the room, pull the covers over her head, and hide. When she was an active woman, she never felt like crying, but now she cannot stop.

Ken is a custodian at a manufacturing company. He has had some mental problems, but his company is very protective of him. Ken is afraid of Nancy's pain and deterioration, cannot face the reality of her illness, and chooses not to hear that her illness is terminal. Nancy would like to share her feelings with Ken, but he leaves the room so that she feels lonely and isolated. Ken tells her he loves her; however, he cannot bring himself to sit beside her and hold her affectionately. Nancy believes if one faces the truth, the truth will set one free.

Ellen, who also has some health problems, stays with Nancy as much as possible. Ellen works from 3:00 p.m. until 11:00 p.m. in a restaurant. It is a strain on Ellen to try to keep two households going.

QUESTIONS:

1. Withdrawal and depression are significant problems for Nancy. How might team members contribute to helping Nancy cope with the emotional turmoil she is experiencing?
2. Nancy’s relationship with her husband, Ken, could be a source of strength for both of them. Suggest approaches which might assist in bringing Ken into a stronger supporting role.

3. Ellen, her daughter, has two households and personal health problems with which to deal. In what ways can hospice team roles contribute to alleviating this stressful situation?

4. The spiritual dimension is not an apparent concern for Nancy. Suggest how team members might be sensitive to the possibility of unspoken needs in this regard.

NO. 2 - RANDY

Randy is a thirty-year-old patient with an advanced case of AIDS contracted through contaminated needles when he was intravenously using heroin. His brain is now affected, and his behavior is sometimes bizarre, e.g., urinating in inappropriate places. He moves with difficulty and spends nearly all of his time watching television, even if someone wants to visit with him. He shuts himself off from his wife, Margie, by his absorption in television, but he does like to have their four-year-old son near.

Randy is angry at life and takes no precautions about protecting his wife from his disease. He and Margie both feel the stigma from others who associate AIDS with homosexuality. Randy and Margie resent this and find that their few friends are staying away. Margie has fears that she and their son will contract AIDS.

Margie has considered hospitalization for Randy but has guilt feelings as Randy wishes to die at home. Margie tends to use alcohol as an escape from the problems.

Randy says God would not allow such suffering if there were a God. Margie believes there is a God and wants her minister to call upon Randy. Randy has never had anything to do with the church and does not intend to start now.
QUESTIONS:

1. Anger and isolation characterize Randy's behavior. How might team members contribute to bring these emotional behaviors into perspective for Randy, his wife, and friends?

2. The "AIDS stigma" creates additional problems as the family seeks to cope with Randy's illness and impending death. Deteriorating behavioral problems may result as the disease progresses. What approaches might be taken by hospice team members to alleviate family stress generally and the stigma they associate with AIDS in particular?

3. Margie uses alcohol to escape. How can this potentially complicating behavior be taken into consideration and dealt with by the hospice team?

4. What is the potential for hospice team members to help with the spiritual conflict between Margie and Randy?

NO. 3 - DORRIE

Dorrie is a sixty-year-old patient with cancer of the breast which metastasized to the lungs. She lives with her husband, Ralph, in a small, rented home. Her mother, a daughter, two sons and their families are in and out daily. Ralph has rheumatoid arthritis and cannot work. He and Dorrie are on welfare programs because of their health.

The family pattern of interaction is one of put-downs, rough talk, and strong threats. Underlying this, however, are concern, caring, and a willingness to help each other.

Dorrie lies in her hospital bed in the living room and feels no embarrassment about her body or her physical needs. There are no secrets in this household.

At first, Dorrie alternately twinkled and scolded, expressing her feelings freely. She is now depressed and often says, "What's the use?" She sometimes refuses chemotherapy and is very sensitive to heat and cold. Her appetite is poor, which distresses Ralph as he believes one has to eat to get
well. He feels she doesn’t try to get up as much as she should and get out of the house as much as she can. She likes lying in bed and wants to make her own choices instead of constantly being told to do this or to do that. Dorrie wants to feel physically close to her husband, but he prefers to sit on the couch. He is meticulous about administering and charting her medications.

Because Dorrie and Ralph have just recently moved here from another state, there is no church involvement or support of friends.

QUESTIONS:

1. Family support appears to be present. How might this strength be enhanced to help both Dorrie and Ralph through the increased depression Dorrie is feeling?

2. What are some actions the team members could take to enhance and strengthen husband Ralph’s interaction with Dorrie?

3. The absence of friends and church connections in the city may have implications for Dorrie and Ralph’s spiritual needs. How can hospice contribute most productively in this area of concern?

NO. 4 - ELEANOR

Eleanor is fifty-seven years old and has cancer of the rectum with liver metastasis. She and her husband, Bill, live in a home they built. Bill is now retired, and Eleanor had to give up her secretarial work when she became ill. Their two daughters are grown, living in different states. Each is happily married and has three children. Eleanor’s husband has deteriorating eyesight which worries her.

Eleanor continues with her community interests on a limited basis, but is increasingly confined to home. She accepts her impending death, but she cannot convince her family that her condition is as serious as it is. She has been the strong, pivotal person in the family, and they think she can continue fighting cancer. Eleanor has even had them feel the growth around her waist so that they will know to what extent the cancer has spread.
Eleanor’s concern is for her husband and her children. They are a closely-knit family with wonderful memories of happy times together. Christmas has always been at the home of Eleanor and Bill, and Eleanor knows that this Christmas will be her last. Eleanor has anxiety as to how her family will deal with her death. She loves her grandchildren, and it hurts her to think that she will not be able to watch them grow. However, she is not afraid of the death process; she believes in her Christian faith. She wishes her family would understand that she will not recover and give her permission "to go.”

QUESTIONS:

1. Lack of family acceptance of Eleanor’s impending death appears to be an important concern which could be addressed by hospice. How might team members contribute to family acceptance of reality?

2. With the approaching holiday season, there will be special individual and family traditions which may be affected by Eleanor’s anxiety that the family accept her approaching death. How can hospice team members help Eleanor and her family through this period?

3. Spiritual strength, as it sustains Eleanor, provides an opportunity to bring the family together. Consider hospice team roles in building upon this strength.

NO. 5 - DAVID

David is an eight-year-old with rhabdomyosarcoma. He has had the full courses of chemotherapy and radiation. His major problem is respiration difficulty, and he is on continuous oxygen. Because he cannot get his breath comfortably, he sleeps sitting up. He is weak and thin, has no hair, and has trouble eating. David spends most of his time in bed, watching television, but he can go into other rooms in a wheelchair. He does not want to see any of his friends.

David’s mother, Beth, became a widow from her second marriage soon after David was born. However, she has four grown children with families from
her first marriage. One son lives in the same city, and his wife comes to help
with David when she can. Beth has support from her unmarried brother who
has come to stay with her. He is also very good with David. The mother wants
no volunteers in the home.

Beth says that David has hardly begun to start living his life; it is unfair for
him to have cancer. David understands what is happening to him and wants his
mother with him constantly. Both of them are frightened. Beth has not had any
church involvement for years, but feels it is very important to have David
baptized.

QUESTIONS:

1. With David's isolation from friends, how can team members contribute
to providing relief to his mother?

2. How can the team cope with the mother's refusal to have volunteers in
the home?

3. How can team members provide an opportunity for the mother to
pursue her desire to have David baptized?

NO. 6 - NAOMI

Naomi is a seventy-five-year-old patient in the end stage of cancer of the
breast with metastasis to the abdomen and chest. She and her husband,
Henry, appreciate and enjoy their two grown children with their own families in
other states. Naomi has chosen not to have additional treatment, has no pain,
has thrown away her pills, and is just waiting "to go." As a former teacher of
home-bound and hospital-bound students, she says she learned courage from
those terminally-ill students for whom she was responsible. Though she would
privately cry over them, she has not allowed tears for her own illness as she
believes they would weaken her.

Naomi and Henry have been active in community affairs and learning.
Religion is the foundation of their lives. Even now, Naomi is doing phoning for
the church. She feels God holds her hand and that we do not ask enough of
Him. She has prepared the details of her arrangements after death, including a
memorial service with special music. She has a printer's proof of the folder with all but the final dates. On the first page is a lengthy quotation from Emerson's *Journal*. Letters are already in envelopes for each attendee; they will be sent to friends who cannot be at the service. She says that she has had a happy, full life and will be waiting at the Heavenly Gate to greet friends and family.

Henry has had a five-bypass heart operation. Naomi is concerned about his adjustment to life without her. Tears come to Henry's eyes when he thinks of being alone. Henry and Naomi have made arrangements for him eventually to move to a retirement community in a familiar area.

**QUESTIONS:**

1. Explain how you view Naomi's cheerful acceptance of death and lack of grieving.

2. Henry's adjustment to Naomi's impending death appears to pose a problem which might be addressed by the hospice team. How can Henry be helped?

3. What are the strengths in Naomi's case which help the family? What are other potential areas of concern?

**NO. 7 - CALVIN**

Calvin is a fifty-year-old patient who has cancer of the lung with metastasis to the brain. Divorced, with a home of his own, he has been living with his eighty-year-old mother since his illness became more than he could manage alone. His twenty-four-year-old daughter Cindy has come home from a great distance to help care for him. However, she is heavily involved with a male friend in the city and sometimes uses alcohol to excess. Although her role is to help her father during the night, she is not dependable. She often goes to her friend's house to escape her duties and her grandmother's talk. Her grandmother has been especially fond of Cindy, favoring her over the other grandchildren. She can do no wrong in her grandmother's eyes, even though Cindy takes advantage of her grandmother financially and in other ways.
Calvin's other daughter, Joyce, who lives in another state, has come twice to visit. She and Cindy fought over how to administer their father's medication, as Joyce felt Cindy was making him choke by having him drink from a glass, rather than using a straw. Joyce is loving to her grandmother, but the affection goes unacknowledged.

Calvin's brother, who lives in the same city, is concerned about Calvin's welfare and the undependability of Cindy. However, the mother will not listen to his concerns or accept his help, and she is not close to his wife or children.

The minister comes to visit occasionally, and Calvin's friends drop by regularly, even though he becomes increasingly less alert. The mother is an energetic person who says that she is all right and can handle things without volunteers. She took care of Calvin's father during his terminal illness a few years ago.

**QUESTIONS:**

1. How can the team best respond to the need for dependable night-care by daughter Cindy?

2. How can hospice team members respond to family conflicts as they relate to Calvin's care?

3. With Calvin's increasing mental and physical deterioration, how can hospice assist his eighty-year-old mother who insists on taking full responsibility for Calvin's care?

**NO. 8 - SARAH**

Sarah is a thirty-eight-year-old patient who has cancer of the cervix with pelvic involvement. She is thin and gaunt although she eats fairly well. She and her husband, Kevin, have four children: Samuel, fourteen; Susan, eight; Stewart, four; and Sally, two. Kevin is feeling a great deal of pressure from his court reporter's work, Sarah's illness, and care of the children. Sarah's parents and married sisters have come at different times to stay for a few days to help out. The fourteen-year-old boy is aware that his mother will not live. Family members think that the younger children believe their mother is just sick.
Sarah has always handled the finances for the family, including all check writing. Kevin is a college graduate, but comes from a culture where the wife is in charge of all the housekeeping responsibilities and care of the children. The husband, however, is the head of the house and makes final decisions. Sarah retired from her newspaper mailing-room job when she became ill. She is concerned about the financial future of the family as they will be living on her husband's income, and he is inexperienced in finances. She hopes that any funds left over from her funeral expenses will be handled wisely.

Sarah has a strong will and keeps as mobile as possible. In the hospital she managed to rally and go home when others thought it would be impossible. Her condition, overall, is deteriorating rapidly.

QUESTIONS:

1. Hospice team members will need to be concerned with assisting the children through the death of their mother. What steps might be taken to address the needs of the children?

2. What can the hospice team provide to help Kevin with his added responsibilities for family finances?

3. How can assistance be provided to help Kevin and the children in anticipation of the change to a single-parent family?

NO. 9 - CONNIE

Connie is a fifty-year-old single person who has cancer of the pancreas with metastasis to the liver. Because of her sister's death, Connie took on the responsibility of her nephew Ted's care when he was a small child. He is now twenty-eight, and he considers Connie his mother. Their relationship was good until Ted graduated from high school.

When Ted entered college, he became involved with a woman who Connie felt was his downfall. He began to abuse drugs and dropped out of school. He has been through drug treatment twice, has been in and out of college, and is currently living at home with Connie. Basically, he is a good person.
Connie and Ted now have a love-hate relationship. They often use violent words, and Ted assumes little responsibility at home, although he is a paid caretaker of Connie under Title XIX. He feels he is being treated like a seventeen-year-old by Connie and resents that. He and Connie are both intelligent people, and Ted’s interest in science is all-consuming to him when he is not using drugs. He is almost a senior in the local college and has an intense desire to learn, but the lure of drug use sometimes overwhelms him.

Ted refuses to work for minimum wages as this would be beneath him, and he expects Connie to pay his expenses. He has also taken some of her prescribed narcotic pain medications and used them himself when he was panicked for drugs. Connie is worried about him, but she is also greatly concerned about death and her own soul and searches for answers about religion.

**QUESTIONS:**

1. How can the hospice team assist Connie in minimizing conflict with her nephew?

2. Ted must not have access to Connie’s medication. How can hospice team members assist Connie in keeping this problem under control?

3. Connie feels a strong need to get her spiritual life in order. Where and how can hospice contribute most effectively to help Connie?

**NO. 10 - GRAHAM**

Graham is eighty years old and has cancer of the lung with metastasis to the spine. Being cared for in a nursing home, he is losing his sight, has only peripheral vision, is becoming more confused, and now is confined to his bed. His work involved much traveling, and he always prided himself on remembering dates, places, and events. Now he is frustrated by his loss of memory.

His wife, June, was visiting him regularly at the nursing home. She now has developed a physical condition which prevents her from driving. The doctor recommends complete bed rest for a time. June feels guilty that she cannot care for Graham at home because his greatest desire is to return there. She
manages to get her meals and do a minimum of housework. Her married
daughter lives on a farm and commutes to work in town, helping her mother as
much as possible. The two grown grandchildren attend college thirty miles
away and stop in to see each grandparent when they can.

June says she tends to be a pessimist and wonders about all the
insurance matters which Graham had not shared with her. She worries about
her husband's coin collection and all the antiques she has collected. There
have been some burglaries in the neighborhood, and she is afraid of being
alone.

June and Graham have had a busy, full life, with both of them working
until retirement.

QUESTIONS:

1. Graham has special needs related to his frustration over his failing
memory. How can hospice team members be of help to him with this problem,
his failing sight, and increasing confusion?

2. In what ways can June be assisted with her guilt over not being able to
have Graham at home or visit him regularly in the nursing home?

3. What assistance can hospice provide in helping June with financial
matters, living alone, and feeling safe in her home?

NO. 11 - CLARA

Clara is a seventy-year-old retired secretary who has cancer of the lung
with hemoptysis. She never married. Her parents and nine of her siblings are
dead, and the remaining brother in her family lives in an adjacent state. His son
lives in the same city as Clara who resides in a trailer court. She often eats in a
little restaurant next door. At home she frequently substitutes alcohol for food.

Clara is an alert and intelligent woman, but her drinking sometimes
causes her to be confused. She is a spunky, resourceful lady whose
observations are pointed and entertaining. Clara challenges authority, has not
accepted the fact that she has cancer, and is angry at her doctor for suggesting
that she is terminal. Extremely strong-willed, in the past she had refused all
treatment or admission to any hospital. Recently, she began coughing up so much blood that she was forced to go to the hospital. She would not allow any blood transfusions or special procedures. When she was able, she released herself from the hospital and went home.

Clara's nephew has given up all hope of ever counseling her on what might be the best decisions. Clara is becoming progressively weaker and has developed a bad cough. Despite her increasing debilitation, she remains concerned about the elderly and plans to write to the President of the United States and her Congressional representatives.

QUESTIONS:

1. How should hospice team members deal with Clara's anger toward the doctor and her nonacceptance of the terminal diagnosis?

2. How could hospice team members best enhance Clara's remaining time?

3. Clara's nephew is the only family member in the state. What role could hospice play in extending support to Clara and to her nephew?

NO. 12 - EMILY

Emily is thirty years old and has cancer of the breast which has metastasized into the bones and lungs. She had lived independently in another state but came back to her parents' home when she could no longer care for herself. Losing her hair from chemotherapy seems not to bother Emily, and she is not interested in wearing a scarf or a wig. She talked with her father during the early part of her illness to tell him she wished cremation. She is not particularly close to her mother. She no longer wishes to discuss her private feelings although she admits to being scared. Talking about her condition makes her cry, and then she cannot stop. As that makes her feel worse, she chooses to lose herself in television.

Until her illness, Emily had an active, full life with traveling, tenting, canoeing, and horseback riding. She and family members also enjoyed vacation excursions together. Emily has one brother and one sister and is close to both of them. She is an attractive, pleasant person, but seldom initiates any
conversation and makes no effort to sustain a conversation someone else begins.

Emily says she is not religious. She does not mind the minister coming over from the church where she and her parents are members, if he does not talk too much about God.

QUESTIONS:

1. Emily has support-system needs which might be enhanced by better communication with her father and mother. How might the hospice team pursue or contribute to improving relationships with her parents?

2. Depression and withdrawal are coping mechanisms which Emily uses to escape dealing with her condition. Suggest approaches which hospice team members could use to help Emily.

3. How might team members assist Emily with her spiritual needs?

NO. 13 - NATHAN

Nathan is fifty-two with a history of lung cancer and heart disease. He continues to smoke and drink and tries to ambulate as much as possible. He goes out whenever he has the strength. His wife, Dora, works part-time and tries to take care of him. When Nathan's mother was terminally ill with cancer, Dora cared for her in their home. At the same time she nursed her sick grandfather who also stayed with them. Nathan and Dora slept in the living room during that time. Dora is a loving person and does not complain. She likes helping people when they need it.

Right now Nathan's close friend Tom, with whom he worked at the packing house, is living with Dora and Nathan so that he can assist Nathan during the night while Dora sleeps. Tom was named provider by the Human Services Division, but Dora wants to appeal for an exception to the rule that the spouse cannot be provider. Then she could quit her work until Nathan's death and be home with him. Tom would still help, and Dora would give him financial remuneration.
Nathan is afraid of being out of pain control. He has a brother who is a minister, but in Nathan’s own salty language, he told his brother he didn’t want any prayers because he wasn’t dead yet. Nathan has a violent nature, but he has calmed down because of his illness. He is not involved with his children by his first wife, and the one son and only child by Dora is currently serving time in prison.

QUESTIONS:

1. How can Nathan's fear of pain and his apprehension that the pain will not be under control be dealt with by the team members?

2. The need to resolve the problem of Dora's not being made provider would contribute significantly to alleviating stress and control needs experienced by Dora. What assistance can hospice team members be with this problem?

3. What can the team contribute to Nathan's spiritual needs? How can his brother, the minister, be helped to provide quality family support to supplement Dora and Tom's efforts?

NO. 14 - ROY

Roy, fifty-five years old, is currently in the hospital with cancer of the lung with metastasis to the brain. He also has a history of chronic obstructive pulmonary disease. Roy was a truck driver and likes to tell about all the fights he had during his career. He has always relied on his strength and is finding it difficult to cope with his current limitations. He believes he will get well and fully intends to disregard the doctor's orders not to drive when he is released from the hospital.

Roy has families by two former wives, but he seldom sees or hears from them. Cassie is his current wife, and her daughter by a previous marriage lives about three miles away. The daughter is a single parent, and a power struggle exists between her and Cassie over the child. Cassie is often asked to take care of the boy, and he has become a pawn. The daughter is not supportive of her mother which Cassie very much resents. Cassie is not well and needs help.
She has severe arthritis but would like to have rehabilitation so that she could go back to work.

Cassie is on an emotional roller coaster. She gets upset over something her husband says during her visits to the hospital, brings up past grievances, and vows never to see him again. The next moment she is solicitous of his welfare and speaks of him lovingly. She smokes incessantly but wants to quit because Roy will have to use oxygen equipment when he comes back home.

QUESTIONS:

1. Roy's refusal to accept the reality of his illness and impending death may create problems upon his release from the hospital. How can hospice team members help Roy adjust to his condition?

2. Family support is unstable at best, and Cassie's relationship with her daughter complicates her uneven emotional state as she attempts to deal with Roy's aggressive, recalcitrant behavior. In what aspects of this situation can hospice team members be helpful?

3. Cassie needs to prepare to take care of Roy and feel more secure about being able to care for herself after his death. To do this she would like to quit smoking and have some rehabilitation now so that she could return to work after Roy's death. How might hospice team members help her achieve her goals?

NO. 15 - BETTY

Betty is a sixty-year-old widow with no children who had to take early retirement from an insurance executive position because of ill health. She has cancer of the lung with metastasis to the bone and trachea. Betty is an attractive, well-groomed woman who took great pride in gourmet cooking and making her home comfortable and nicely decorated. She can no longer live alone and has offered to go to a nursing home. However, her two nieces insist that they will take care of her as their mother, Betty's only sibling, would want that. Betty's sister died of cancer two years ago. The nieces take turns driving
the three hours into the city and staying for a week at a time. Their husbands have been very supportive of this for several weeks, but they are beginning to tire of having their wives gone so much.

Betty is becoming more and more demanding and hard to please. If she wants a cigarette in the middle of the night, the niece has to get up and sit with her while Betty smokes. Betty is reluctant to take pain medication even if she is hurting. She always says to visitors that she is fine. She is a very private person, and the level of conversation is casual except with the nieces. The visits from her minister are helpful.

QUESTIONS:

1. What can hospice team members do to work with Betty’s nieces to ensure family support and acceptance of the nieces’ role in caring for Betty?

2. Care for Betty during the night is often difficult and tiring for the nieces. How can the assistance needed be provided, and what might be the role of hospice team members?

3. How can the team encourage Betty to use her pain medication most effectively?
SECTION II

QUOTATIONS FROM PROFESSIONALS ABOUT HOSPICE WORKERS

The following quotations provide a focus for discussing selected work-related hospice issues.

1. "According to an oncologist and radiation therapist, "Many doctors see hospice as a tremendous intrusion on a very sacred part of medicine - helping people to die. . . . The doctor is basically taken out of the driver's seat."

"One Omaha doctor who asked not to be identified said he wanted tests for a hospice patient to determine whether a condition existed that could be corrected to allow the patient a better life in her remaining days. He said the test was not taken because the team refused." (6)

Questions:

How can physician concerns be dealt with in the best interests of the patient within the hospice setting?

Who should be in the "driver's seat"? Why?

2. "Everyone knows some helping professionals who simply deny that they are personally affected by the plight of their patients." (7)

Questions:

What action might be taken to identify potential problems related to the denial of personal impact related to patient suffering and death?

How might this behavior (denial) be dealt with as an ongoing potential problem for the staff?
3. "Both professionals [nurses and social workers] appear adequately qualified to perform their jobs. Nurses and social workers on the hospice team must lose their sense of territoriality, no longer resist the sharing of information or be defensive regarding assessment and intervention. Independent and parallel functioning should be abandoned, and neither the hospice nurse nor the social worker should carry on a private practice under the guise of teamwork." (8)

**Questions:**

What are examples of possible territoriality for the nurse, social worker, and others on the team?

Identify strategies for reducing potential conflict related to territorial concerns.

4. "It is important to remember that the social work goal is not to perfect the client and family, but to support them by assisting with whatever needs they have at the time." (9)

**Questions:**

Why might this be a problem?

How can the work of all hospice professionals be focused on support and assistance rather than change?

5. "Recent evidence suggests that the greatest stress for hospice caregivers comes not from working with the dying but from preventable administrative and structural problems. A study of stress in hospice by Rosemary Yancik reported in the *Journal of Psychosocial Oncology*, Spring, 1984) . . . concludes that the caregivers' reports of what was most stressful in their hospice work involved the type of stress that may be eased by the administration. That is, the opportunity to moderate the strains of hospice work is rooted in the environment of a hospice. The implication of the finding is that even though the stress of hospice work cannot be avoided or eliminated, it can be reduced for specific work problems." (10)
Questions:

What are potential or real sources of stress related to administrative functions and support?

Consider methods of anticipating and dealing with the realities of hospice work which, while stress producing, must be carried out.

6. "Hospice nurses and social workers are required to work much more closely and cooperatively [than in hospitals]. Indeed, often their roles overlap so that what might under other circumstances be considered a job for one and not the other becomes in hospice a shared responsibility. . . . As nurses become aware of the personal emotional needs of patients and family, they pass these on to the social workers. At the same time, as the social worker becomes aware of unfilled patient and family needs, she makes the nurses aware." (11)

Questions:

Draw up a list of duties which each worker might identify as primary concerns.

Develop cooperative functions which help address responsibilities primarily carried out by individual team members.

7. "Humanitarian motives which lead bright, educated young people to the helping professions may be clouded by an emotionally draining situation for which they are not prepared, by virtue of either experience or education. The compensation of possible patient improvement is generally not present in a terminally ill . . . population. Thus, the need for measurable fulfillment is unmet." (12)

Questions:

What are the elements in hospice work which provide a sense of job satisfaction?

How might this need for fulfillment be provided for through staff activities?
8. "Children are very perceptive to adults' sadness. They feel the emotion; however, when they do not know the whole story, the gaps are filled in with their own fantasies. Unfortunately, their fantasies are far worse than the truth from which they are being 'protected.' Likewise, in turn, youngsters may try to protect their parents. A grieving child may choose not to discuss his or her feelings with the adults he or she trusts most, because of not wanting to make them feel sad. A real communication problem is likely to develop." (13)

Questions:

What are special needs that a child faces in his/her own or a family member's death?

How can hospice team members identify and address these concerns and needs?

9. "Because of the sustained intimacy that characterizes hospice ideology and caregiver role behavior, hospice staff members are particularly vulnerable to stresses associated with over-investment and over-involvement. To be effective on a long-term basis and to avoid burnout, it is essential that hospice caregivers learn how to balance self, peer, and ideologic expectations. They also need to be responsive to the holistic needs of patients and family members while at the same time making an effort to meet their own needs for nurturance and replenishment." (14)

Questions:

How can individuals recognize and cope with stress build-up?

What activities can team members undertake to address prevention, reduction or management of stress?

10. "A final, but most encompassing reason why professionals dealing with life-threatening or dreaded diseases have a task to help themselves rests in the existential message that such diseases convey to all who come in contact with them. This powerful--and, for some people, overwhelming--message about life itself is that life is a going-to-death--inevitably, irrevocably, unalterably. Death is a foredoomed fact of life, which even though well-
known intellectually, has been protested passionately throughout the 
history of mankind. Although everyone knows that death is intrinsic to life, 
we seek to avoid confrontations with its manifestations if we can. But this 
avoidance is precisely what professional helpers of patients with dreaded 
diseases cannot do or can only try to do through fantastic acts of mental 
trapeze work, for just such manifestations are their daily fare.” (15)

Questions:

Discuss personal perspectives on death as held by individual team 
members.

Develop a strategy for providing support among team members in 
maintaining balance as they seek to reconcile death as a reality for themselves 
and their patients.
In their efforts to be helpful to patients and families, hospice workers are not always aware of the perceptions of the receivers of hospice services. The following comments made by patients and/or families may be used as starting points for discussion.

1. "People should tread carefully in possible manipulation of lives."
   **Q:** How might hospice people unknowingly become involved in manipulation in patient's lives? How might team members deal with bringing about change without manipulating?

2. "I get tired of everyone always telling me what to do and when to do it. The nurse is too bossy."
   **Q:** How do you engage in constructive interaction to achieve patient cooperation and self direction? How does this comment fit in with the hospice philosophy that the patient and family are in control?

3. "I don't want my daughter's problems to be the focus because I'm the patient."
   **Q:** How do you keep the patient as the focus of the hospice team's efforts?
   How involved should hospice team members become in family patterns of long-standing?

4. "I don't want to talk about what is going to happen to me."
   **Q:** How do hospice team members provide opportunities without forcing issues and topics upon patients and/or families? Is denial a legitimate right of the patient?
5. "We don't like people poking their noses into our business."
   Q: How can you seek information which will be helpful, yet not intrude on the privacy of the patient and family?

6. "We are a private family. We don't like a lot of questions."
   Q: What assurances can you give that the information is necessary for their benefit to help the patient and family through the dying process?

7. "I don't like hurting people's feelings, but sometimes I really don't want to accept some of the offers of help by volunteers or other hospice people."
   Q: How can we assess how the patient and family really feel about different aspects of hospice service?

8. "I'm afraid if I don't let them do what they want, they won't come back."
   Q: How can hospice workers be sensitive to wishes or real needs of the patient and family and let them understand that "no" is an acceptable response?

9. "I like the psychosocial worker, but I don't have time to sit down and visit every week."
   Q: How can hospice workers recognize and respect the time constraints of the family and patient?

10. "I know why you're here. You're here to see if I'm coping. Well, I'm coping."
     Q: What might this commentary suggest concerning patient-staff relationships?

11. "Why are you here and what do you want?"
     Q: Why is the patient asking this question? How do you prepare for your visit so that the patient and family have a clear understanding of your purpose?

12. Who decided I need a social worker? I don't."
     Q: How do the hospice workers let the patient know that their roles are supportive rather than directive?
IN CONCLUSION . . .

Building a sense of teamwork as a basic requisite to success for hospice workers is an ongoing task. While this series of exercises focuses on patient and family care provided by the nurse, psycho-social worker and chaplain, there is no intention that staff participation be limited in those particular professionals. The team-building activities should seek to benefit all volunteers and professional staff through understanding patient and family circumstances, concerns and needs. For example, the Directors of Bereavement and Volunteer Services should profit from and contribute to the interactive team building process.

Staff members and discussion leaders are urged to use the exercises as starting points or as introductory scenarios upon which to build or base an exploration of possibilities for providing the most effective patient and family services. Relating these examples to on-going experiences can be beneficial for experienced as well as inexperienced workers. Open interaction will build an understanding of one's self and one's role in relation to the roles and responsibilities of other team members, thus affecting both the service providers and the recipients of the services. With on-going attention to team building as a technique for enhancing staff interrelationships, the ultimate benefactors will be the patients and their families--and, after all, that is really what hospice is all about.
NOTES


8. Donovan, 22.


11. Heintze, 2.


15. Pruyser, 359.
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