

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

As there is a scarcity of literature pertaining specifically to hospice volunteers, this study has also drawn on writings pertaining to hospice staff in general and volunteers in general. The literature reviewed in this study confirmed Uffman's (1993) statement that the current body of knowledge concerning hospice workers and volunteers concentrates on specific aspects such as motivation, role and stressors as opposed to providing an integrated picture of volunteers and their experience. There is likewise no overriding theory in this area of research and a lack of integration in current theories is evident. Theories of stress (Glass & Hastings, 1992), altruism (Kottler, 2000), and Maslow's hierarchy of needs (Uffman, 1993) amongst others, are used to explain different aspects of volunteerism. Some of these theories and various research findings will be discussed in this chapter.

2.2 MASLOW'S THEORY AND THE VOLUNTEER

Maslow's career focused on teaching, research and writing. The observations he used for his theorising stem from research on normal and creative people rather than those with psychopathology. His focus of concern was for the betterment of society and individual life (Maddi, 1996). Maslow's theory falls under the humanistic approach in psychology that emphasises man's motivational drive towards growth and self-actualisation (Maddi, 1996). It was influenced by the writings of Rogers who also endorsed a master motive for behaviour, a core tendency in the personality to push towards actualisation of inherent potentialities (Calhoun, Acocella & Goodstein, 1977; Maddi, 1996). In the fulfilling of potentialities people become whatever it is that they were destined to be. The inner nature expressed is what would culturally be considered to be good or neutral. According to Maddi (1996), Maslow's view of inherent nature is 'prior good and evil' (Maddi, 1996 p. 117). The type of person likely to volunteer has

been described as self-actualising in terms of Maslow's theory of personality (Uffman, 1993).

The other core tendency in the personality acknowledged by Maslow is the survival tendency - the push to satisfy psychological and physical needs necessary for survival. This survival tendency appears prior to the actualisation tendency in that it has to be satisfied to some extent before the actualisation tendency can be fully expressed. This for Maslow is the main importance of the survival tendency (Maddi, 1996). In terms of this theory volunteers' survival tendency should be satisfied before they self-actualise through volunteering.

To express this successive order of satisfaction and development Maslow introduced the concept of the hierarchy of needs. He presents five levels of needs that have to be satisfied one by one during the process of development in order for self-actualising to take place (Calhoun et al., 1977). Firstly, biological needs for physical comfort and survival have to be met. Secondly, safety needs have to be met by the provision of a stable, structured, predictable environment. The third need is for belonging and love, which includes pleasure in and interaction with friends and family. On the fourth level are esteem needs that involve gaining respect from others, which leads to the creation of the internal resource of self-esteem. Finally the individual can go to the fifth level of self-actualising (Calhoun et al., 1977). With those involved in volunteer work the first four levels of Maslow's hierarchy of needs should have been already met.

The two core tendencies result in two kinds of motivation for behaviour. The survival tendency provides deprivation motivation and the actualising tendency provides growth motivation. The core survival tendency maintains life while the core actualisation tendency enhances it. According to Maddi (1996), the importance that Maslow places on the latter makes his position a fulfilment theory (Maddi, 1996). Maslow believes that people need more than simple adjustment, which is why he examines the actualising process whereby the personality builds

up (Calhoun et al., 1977). The process looks at developing the positive and creative aspects of the individual and the basic need for the individual to develop his potential to the fullest, to progress beyond what he is now (Hilgard, Atkinson & Atkinson, 1975). Maslow's position is interested in the individual's subjective experience of himself and the experiences that make life meaningful (Hilgard et al., 1975).

Maslow describes the self-actualised person as one who has peak experiences, unselfish love and unbiased understanding. Volunteers should resemble Maslow's self-actualised person. The self-actualised person is said to possess the following traits. They:

- are accepting of themselves and the natural world
- are realistic in orientation
- are task orientated rather than self-preoccupied
- recognise the difference between means and ends
- are spontaneous
- are independent
- are appreciative
- are spiritual
- have a sense of privacy
- identify with other human beings
- have feelings of intimacy with a few people close to them
- have a sense of humour
- are creative
- are nonconformist with democratic values.

For Maslow mental illness is associated with faulty actualisation (Maddi, 1996).

Maslow's theory is not without criticism. According to Maddi (1996), history provides many contrary examples to this progressive process of development towards self-actualisation. Many people who have been significantly deprived of

nurturance and suffered economic deprivation have overcome these difficulties and accomplished much. For example John Bunyan began writing Pilgrim's progress from the confines of his prison cell (Maddi, 1996).

2.3 VOLUNTEERING AS AN ECONOMIC ACT

Volunteering has also been described as an economic act involving bartering. According to Muller cited in Unger (1991), volunteers are compensated for their work in four ways:

- 1) the family unit consumes the collective good, e.g. donating blood to ensure a future supply for family members;
- 2) the volunteer enjoys a selective incentive - prestige or social contact;
- 3) the family's human capital is improved - education, or some other form of building skills or maintaining skills, while not participating in the job market, is attained;
- 4) or an altruistic motivation is served. Altruism is a motivation focused on the need of others. Volunteerism is reported to be an act equated with good works within the Judeo-Christian framework, the reward being intrinsic to the act itself. Traditionally, altruism was not emphasised as a motive for pro-social behaviour. This was accounted for rather by self-serving motivation. In the last decade the view of humans as being purely self-serving has been questioned.

2.4 THE THEORIES OF ALTRUISM

Hunt (1990) describes altruism as a form of pro-social behaviour that defies the laws of reinforcement in that the acts run counter to self-interest. It is behaviour that is carried out to benefit another without the anticipation of gaining external rewards (Hunt, 1990; Jankofsky & Stuecher, 1984). Altruism has been used to explain the behaviour of volunteerism as it seems that the rewards of volunteerism are intrinsic to the act itself (Unger, 1991). Those who believe that human nature is basically selfish claim that true altruism does not exist. Altruistic acts are seen to result in rewards such as return favours, public esteem or

internal satisfaction (Hunt, 1990). Numerous theoretical explanations have been proffered to account for altruistic behaviour. A brief review of some of them follows.

2.4.1 Genetic Theory

In the genetic theory, the origin of altruism has been attributed to genes. A twin study by Rushton, cited by Hunt (1990), utilised questionnaires and statistical analysis to look for genetic evidence of altruism. Identical twins were found to be more alike in their tendency toward altruism or selfishness than fraternal twins. The end results indicated a 50% heritability of altruism. The problem with this theory is that as the altruistic act serves to diminish the altruist's chance of survival, why then has it not led to the extinction of those who are genetically predisposed to it? To solve this problem theorists shifted the focus of evolutionary competition from the individual to the group. Altruism is said to evolve through group selection in that those groups containing altruists are more likely to survive than a group without any. This theory however cannot account for altruism in any species whose members have considerable genetic variation. For example a human group would contain both selfish and altruistic members, and the survival of the selfish above the altruistic would not preserve the altruistic genes (Hunt, 1990).

2.4.2 Kin Selection Theory

Kin selection theory proffers that in acting to benefit relatives the altruist is preserving his own genes, including the altruistic gene (Hunt, 1990). Evidence for kin selection theory has been noted in the animal kingdom. Kottler (2000) states that male lions kill the offspring of vanquished lions and new mates so that they do not invest in caring for offspring that are not genetically attached to them. Humans would seem to follow this same pattern when research shows that child abuse is 100 times greater when a step-parent is in the home (Kottler, 2000). Kottler (2000) extends the definition of kinship to include those sharing a similar interest. He states that evolutionary advantages are only part of the benefits for

behaving altruistically to blood relatives and even extended family or those with shared interests. There is a kind of self-interest involved in helping those who share your genes or at least mutual interests such as your church or team. When members of your team do well, it reflects favourably on you too (Kottler, 2000). This theory does not explain how in a large society individuals can behave compassionately towards people who are not their kin, but total strangers. Kinship selection theory accounts for only a limited type of altruism (Hunt, 1990).

2.4.3 A Biological Basis for Altruism

Luks (1988) describes research done on the 'helpers high' which explores the hormonal and neurological changes that take place during altruistic acts. The effects of helping others are reported to be the same as those of a vigorous workout. During a workout a 'feeling high' ensues followed by a sense of calmness and freedom from stress afterwards. Similar results have been reported following helping acts (Luks, 1988).

The increased highs and calmness after helping others may be the result of the release of endorphins (Luks, 1988). The helper's pleasurable, physical sense of calmness is the opposite of the body's agitated condition under emotional stress. Emotional stress leads to the adrenal gland releasing stress chemicals, the corticosteroids. These chemicals lead to an increase in cholesterol levels, blood sugar levels, heart disease and a decrease in the immune system functioning. The helper's calm seems to be associated with reduced emotional stress. It has a lasting effect over highs induced from exercise in that the memory of these moments can also bring a recurrence of the original high, although this is less intense. Research indicates neural mechanisms that predispose us to act altruistically (Luks, 1988). We are then subsequently rewarded by our endocrine system with feelings of well being (Kottler, 2000). This altruistic pleasure appears to arise from close personal contact, as this has to be involved in the helping act for this experience to occur (Luks, 1988).

Luks (1988) also reports health benefits arising from helping others. He carried out two studies on women volunteers only. However, they matched the national volunteer profile, in that they were primarily married, and were broadly representative in age and region. Results indicated nine out of ten committed volunteers report that they are as healthy or healthier than others of their age. These results matched nation-wide surveys (Luks, 1988). However, being in control seems to be related to the health benefits associated with giving to others. Caregivers who have long term duties of caring for the elderly often report more stress and health problems than others their age (Luks, 1988).

2.4.4 Altruism as Learnt Behaviour

Part of altruism seems to be biologically determined. The human mind however has the capacity to learn forms of behaviour through cultural evolution. A large part of altruism is culturally and experientially determined. Parents who are warm and nurturant instil the pre-requisites for the development of empathy in their children (Hunt, 1990). Researchers have confirmed this, finding correlation between parental warmth and altruism in children. A study found that four year old boys who were most generous in experimental situations were found to have particularly warm and affectionate father's (Hunt, 1990). Another study reported that altruistic ten-year-old boys had warm mothers (Hunt, 1990).

The experience of parental warmth promotes the development of altruism in another way - parents act as role models for their children. Helping then becomes part of a life style. People do good because it is the way they were brought up (Hunt, 1990). Clary and Miller (1986) examined socialisation and situational influences on sustained altruism. Volunteers with a socialisation history of exposure to nurturing parents who modelled altruism (autonomous altruists) exhibited a greater degree of sustained altruism than those volunteers with a history of less nurturing parents who did not model altruism to the same extent (normative altruists). The altruism of the normative volunteers however

did increase when they were given certain situational conditions. When these volunteers were required to participate in a highly cohesive training group prior to their actual volunteer activity, they exhibited sustained altruism on a par with the autonomous volunteers. The altruism of autonomous volunteers was unaffected by the training group experience.

Internalised moral incentives that have been taught through education, religion and the community can act as rewards for altruistic behaviour (Kottler, 2000). Looking at the effect of disciplinary styles on the development of altruism Hoffman and Saltzstein (1967) interviewed a large number of children and their parents about disciplinary practices. The different disciplinary styles were classified as: power assertion (yelling, spanking and other forms of coercion); or love withdrawal and induction (explaining how the child's actions would make other people feel). The children's moral development was measured by having them make up endings to incomplete stories about cheating and other wrongdoing. The induction disciplinary style led to the internalising of parents and society standards as well as the desired behaviour.

Hunt (1990) gives an example of altruistic behaviour arising due to upbringing and social context. Mrs Marjorie Judge of Southampton, New York is a middle aged, retired teacher who spends half a day each week as a hospice volunteer. She was interviewed and asked why she did what she did and found difficulty in explaining her motives (Hunt, 1990). Although she touches on other issues relating to her helping, the influence of her upbringing is evident. For her it has always been a part of her life style.

Q: What made you want to spend time ministering to dying people?

A: Oh, I had always done things like this. At nineteen I was a counsellor at a camp for handicapped children - kids in wheelchairs, kids in braces, spastic kids all that. Later I was a recreation volunteer on a psychiatric

- ward at a large hospital. And as a teacher, I always worked with problem kids in school.
- Q: But what made you like that? Why were you drawn again and again to such activities?
- A: I don't know... I've always been very people-orientated. I need people around me.
- Q: Why, in so giving a relationship to them?
- A: Oh, I think it's a two-way street. I feel I come away having received more than I have given. If it weren't satisfying, I think I couldn't do it.
- Q: That still doesn't tell me what made you an altruistic kind of person. What do you think did?
- A: I don't know. My mother was a very loving, giving personality. Also my generation was an idealistic one. When I went to college, we all wanted to make the world a better place. But I don't call what I do altruism. I never use that word. To me it sounds - I don't know - impractical, or pretentious. I do what I do because I feel good doing it (Hunt,1990, p.98).

2.4.5 Reciprocal Altruism

Reciprocal altruism is based on engaging in altruistic acts in order to gain help in return. This form of altruism has nothing to do with acts of kindness and unselfish sacrifice. What is described in this theory is co-operation, a valuable but selfish form of behaviour in which one person benefits another in the expectation of receiving benefits in return (Hunt, 1990). According to Kottler (2000), this kind of altruism that results in a return favour can be conscious or unconscious. We help others because on a conscious level we feel good doing it, but if you are always the one initiating giving you are likely to feel cheated. People seem to remember gestures and whom they are indebted to (Kottler, 2000). This theory does not account for genuine altruistic acts that expect no favour in return (Hunt, 1990).

2.4.6 Altruism Based on Empathy

An empathic basis for altruism has also been put forward. 'Empathy is defined as the ability to take another person's role and behave pro-socially as a result of experiencing vicarious distress' (Unger, 1991, p. 75). It is the mental process whereby we feel what another is feeling even though it is not our situation. It may cause us to act in a way that is not in our own best interest (Hunt, 1990).

Hoffman (1975, 1981) reviewed research where physiological arousal, facial expression and verbal rapport were used as measures of empathic arousal, in response to others distress. The research clearly showed the existence of this involuntary response in both children and adults. There is also evidence of affective empathy as a mediator of helping behaviour. When empathy and helping behaviour are investigated simultaneously, subjects have demonstrated both responses, indicating a correlation between the two (Unger, 1991). According to Hoffman's (1981) empathic theory, part of the choice to help is to extinguish your own pain induced by empathy. With empathic arousal you can imagine what it is like to be in someone's position. One way to reduce your own discomfort is to come to the aid of the other person. Altruism therefore involves reaching out to yourself as well as others (Kottler, 2000). The capacity to empathise is developed via your own painful life experiences, through growing up in a household that displayed empathy or as an innate gift that allows you to sense what others are feeling (Hunt, 1990).

We are also socialised to realise that empathic responses are rewarded by friendship, loyalty and social approval. Hence during development children increasingly empathise with others in distress. It elicits mutual understanding and help and therefore enhances the survival of groups. From this perspective much of altruism is motivated by self-interest even though on the surface the act may seem contrary to this. People enjoy the recognition they receive in manifesting empathy, thus they help themselves by helping others (Hunt, 1990).

2.4.7 Karylowski's Theory: Two Types of Altruistic Behaviour

From the above it can be seen that, as is characteristic of this field of study in general, there is also little integration across theories on altruism (Derlega & Grzelak, 1982). Karylowski's (1982) theory is now included to move towards integration of the volunteer experience as he claims that the various mechanisms of altruistic behaviour as explained by theories can be entered into one of his classification categories. He attempts to classify internal mechanisms underlying altruism using the source of gratification. Altruistic behaviours that are controlled by anticipations of external reward are called pseudo-altruistic and are excluded from his classification system. He sees two possible sources of altruism. The first source is the maintenance or heightening of positive self-image. The second source deals with the improvement of conditions of another person in need or prevention of these conditions from getting any worse. Altruistic behaviour then is seen to be motivated either by a desire to bring about changes in the self or by a desire to alter something in the external world. The first source of motivation is called endocentric altruism in which attention is focused on the self or the self's moral aspects. The second source of motivation is called exocentric altruism where the attention is focused on the external world or on someone else (Karylowski, 1982).

Different situational factors contribute to the source of altruistic behaviour. All factors that focus attention on the self increase the endocentric elements in altruistic behaviour, and those that focus on the environment accentuate the exocentric elements. Any given behaviour is usually due in part to both types of altruistic motivation as well as elements of pseudo-altruistic motivation. However, Karylowski (1982) claims that all of the various mechanisms of altruistic behaviour as explained by theories can be classified into one of these categories. With individual behaviour, or especially of the kind of altruistic behaviour that is typical of each individual person, it is possible to speak of the dominance of one form of motivation above another (Karylowski, 1982).

The major characteristic of endocentric approaches to altruistic behaviour is the assumption that what is reinforcing for the helper is not simply the actual occurrence of certain changes in the external world, or the improvement of someone else's condition, but the fact that this change has been caused by the action of the helper himself. Exocentric centred approaches assume that what is reinforcing to the helper is the improvement of another person's condition. Inherent gratification rests in the observation of this change whether or not the change was caused by the helper or not. The development of endocentric and exocentric altruistic behaviour may be promoted by different socialisation techniques that focus the child's attention either on the moral aspect of the self or on external reality (Karylowski, 1982).

Among the exocentric explanations about the source of motivation two distinct subtypes seem to be distinguishable - cognitive and affective. These proposed explanations assume that awareness of another person in need causes either inconsistency in individual's cognitive system, his cognitive representations of external social objects, or some form of conditioned or unconditioned emotional response (Karylowski, 1982).

It is assumed that exocentric sources will usually be accompanied by conscious focusing on the other in need and their condition. Endocentric sources will focus on questions as to the type of person the helper is and moral satisfaction ensuing from the altruistic behaviour. The endocentric helper might be less sensitive to the needs of others as the helping act may depend on the extent to which a behaviour can restore or maintain their self-concept (Karylowski, 1982).

2.5 RESEARCH FINDINGS ON VOLUNTEER MOTIVATION AND SATISFACTION

It is impossible to relate all the research findings on volunteer motivation to one theory. Referring to the helping role in general, Kottler (2000) states that there are many reasons why people choose to help others - some to address personal

needs, others for altruistic or moral imperatives. For most people it is a combination of many factors that lead to a life devoted to service (Kottler, 2000). Unger (1991) confirms this for the specific category of volunteers stating that they may have more than one motive for coming to their role. In studying volunteers Kiviniemi, Snyder and Omoto (2002) found that volunteers with more than one motive reported more negative outcomes than did volunteers with just one motive. They state that individuals engage in behaviours that they believe will satisfy their needs. The motives guiding people play a significant part in organising their ongoing behaviour (Cantor, 1994; Snyder, 1993).

Research findings indicate, amongst others, the following motivations specifically for hospice volunteers: personal interest, personal experience with the death of a family member (Scott & Cladwell, 1996; Garfield & Jenkins, 1981; Payne, 2001; Chng & Ramsey, 1984), awareness through advertising, the invitation of other hospice workers, the death of a close personal friend (Scott & Cladwell, 1996), religious beliefs, children having left home, spare time due to retirement, and a desire to help others (Payne, 2001).

Ellis (1993) discovered that for volunteers in general the role might also serve to ease the transition from worker to retired person. One's work role forms an important part of one's identity. By involving oneself in volunteer work before retirement and continuing into retirement may make the transition into this period of life easier, allowing the retention of a sense of identity.

Talking of the helping act in general, Kottler (2000) states that it can be a way of giving something back. It can also fulfil a wish to leave a legacy or an impact of how they helped to change someone's situation. There is sometimes a need to rescue or to save someone's life. People feel that helping is endorsed by a higher power.

According to Kottler (2000), the act of helping provides a sense of being part of something bigger than we are and breaks a feeling of isolation. An intimacy takes place in the helping encounter; the connections that develop are so strong that they seem to be at the heart of whatever help was offered. People help someone because they get some kind of reward or they would not continue to do so (Kottler, 2000). There are reciprocal gains attached to volunteering such as those cited by Muller (Unger, 1991), or some form of personal satisfaction is gleaned. It seems there are multiple urges driving all helpers (Kottler, 2000).

Satisfaction from volunteering seems to be linked to the individual motives that initiated it and how expectations arising from these motives are fulfilled during service (Cantor, 1994, Snyder, 1993). Payne (2001) discovered that hospice volunteers involved in a bereavement programme found the following to be the most satisfying aspects of their work: personal growth; acquiring skills; fun; team work; contact with hospice staff; helping families; feedback from patient and families; making patients more comfortable and happy; helping the bereaved recover; being associated with hospice; engaging in community service; talking and listening to patient and family; fulfilling a religious calling; helping with fund raising; and making telephone calls to the bereaved family. Scott and Cladwell, (1996) found continuing in hospice volunteer work to be associated with excellent training, belief in the hospice mission, a positive relationship with staff, feeling valued and personal fulfilment. Uffman (1993) reports in her study on hospice volunteers, that they learn to appreciate life and not to dwell on the negative unimportant things but to live it to the fullest. They realise that they do not have all the answers to death but are happy not knowing.

2.6 STRESS THEORY AND ITS RELATIONSHIP TO THE ACT OF HELPING

Stress is defined as the body's way of mobilising resources to cope with an external threat or danger. It is a self-inflicted condition as it is caused by the individual's perception of a situation as being threatening (Kottler, 2000). Seyle (cited in Maslach, 1982) popularly referred to as 'the father of stress' (Maslach,

1982, p.54) describes stress as a none-specific bodily response to any demand made on the organism. The demands are referred to as stressors. Seyle theorised that the body goes through a three-phased response to sustained stress. He refers to this process as the General Adaptation Syndrome (GAS).

The first phase, the alarm phase, involves major biochemical changes in the body, which occur when a stressor is initially encountered. These changes include an increase in adrenaline, an increase in heart rate, blood pressure, a decrease in the digestive process and a heightening of all the senses. The second phase, the resistance phase, occurs when the stress is being dealt with in some way. The alarm response disappears and the physiological changes that then occur are a function of the particular strategy being used. The third phase, the exhaustion phase, occurs when the adaptive energy for resisting stress is used up. The alarm phase may then be re-activated and the GAS syndrome will be repeated to find a new resistance strategy. If no alternative strategy is activated, the organism will suffer permanent damage or may die. This theory has been very influential in the field of stress, but it is limited as its focus is only on physical stresses and physiological stress responses (Barlow & Durand, 1995 ; Maslach, 1986).

Current stress research places a far greater emphasis on psychological stresses as well as psychological and social responses to stress than did Seyle (Maslach, 1986). For example, Lazarus (1966), a later theorist, considers the perception of the individual in his stress theory. He examines stress through a model of primary and secondary appraisal. Primary appraisal consists of assessing whether there is a risk emanating from the current situation, and the secondary appraisal consists of the selection of coping strategies appropriate to the nature of the primary appraisal. The expansion of the concept of stress has resulted in the increase of the number of definitions and there is now a lot of disagreement as to what stress actually is (Maslach, 1986).

Theories of stress have been applied to the role of helping. The helping role carries with it a number of burdens and responsibilities that lead to stress and personal depletion. Volunteer helpers experience similar problems to those found in the helping profession in general, and additional ones that are unique to their chosen service. Compassion fatigue is the term given specifically to stress emanating from helping others. It is a kind of secondary post-traumatic stress syndrome that comes from being in close contact with those who have experienced negative situations. It is important to look at the sacrifices as well as the satisfaction associated with the helping role. Some of the research findings in this area will now be discussed (Kottler, 2000).

2.7 RESEARCH FINDING ON STRESS IN HELPERS AND HOSPICE VOLUNTEERS

Some of the main sources of stress in the helping profession seem to be: personal transitions (Kottler, 2000; Glass & Hastings 1992); the work environment (Kottler, 2000; Glass & Hastings 1992; Payne, 2001); clients (Kottler, 2000; Payne, 2001); colleagues (Kottler, 2000; Payne, 2001); and the helper's own expectations (Kottler, 2000). Personal stress, such as going through a divorce, health problems or financial issues, can add to the stresses already encountered in the helping profession. Clients can be resistant, angry, manipulative and even dangerous (Kottler, 2000). They could also have unrealistic expectations of the helper (Riordan & Saltzer, 1992). It is difficult to be close to those who are suffering, especially if they perceive you as threatening (Kottler, 2000). Trying to work as a team can be stressful (Glass & Hastings, 1992). Those who are in the helping profession do not always treat colleagues with the compassion that might be expected (Kottler, 2000). Work environments may be infested with political intrigue, backbiting, scapegoating and undermining (Kottler, 2000; Glass & Hastings, 1992). There can be inadequate communication between administrator and staff and between staff members; unrealistic expectations from administrators resulting in staff overload; conflicts and lack of support from co-workers and unrealistic perception and expectation

of professional performance by other staff members can all lead to stress (Riordan & Saltzer, 1992). Other sources of stress noted by helpers are: too high personal expectations (Kottler, 2000; Glass & Hastings, 1992); feelings of isolation (Riordan & Saltzer, 1992); and taking on too much work so that it interferes with family or leisure time (Kottler, 2000). Empathy and compassion, plus training, may make helpers oversensitive to the problems of others. This sensitivity that can become a great asset can also become a great burden, heightening awareness of others' pain (Kottler, 2000).

Maslach (1982) identified several sources of stress that can lead to the dropout of hospice volunteers specifically. Some of them overlap with the sources of stress cited in research on helpers in general. These are: lack of positive feedback from patients and their families; difficult patients that can be demanding, manipulative, non-compliant or clinging; lack of professional or personal support systems; a high need for approval; and unrealistic expectations of own performance. Generally the sources of stress for each volunteer was found to come from their own personality and social life, the relationship between the volunteer and professional staff, and in the work with patients and families (Maslach, 1982). Chronic anticipatory grief, loss, a need to grieve and to come to closure consistently is potentially stressful. Inappropriate motivations for choosing this special field (Riordan & Saltzer, 1992) and fears of death and dying on the part of the hospice volunteer can also lead to stress (Maslach, 1982). Pertaining specifically to the role of volunteer, difference in status between paid and unpaid staff was cited as a potentially stressful by Maslach (1982). Being in close contact with difficult emotions and the anguish of loss can be both psychologically challenging and emotionally distressing (Payne, 2001).

Expanding on the role of motivation as a possible source of stress, Glass and Hastings (1992) state that if the expected outcome for going into hospice work is not achieved, stress can ensue. These motivations include: wanting to resolve past issues, wanting to resolve guilt, assuming a sense of special calling, wanting

to prove to be better at caring for the dying than others and wanting to resolve feelings of past inadequacies (Glass & Hastings, 1992). There may be a particular vulnerability of hospice workers to stress pertaining to wanting to resolve past issues. Typically there is a disproportionate amount of bereavement experiences amongst hospice workers. Past personal loss is often cited as an incentive for going into the volunteer role and could help to bring closure (Garfield & Jenkins, 1981). Alternatively it could lead to increased stress if closure is not attained (Glass & Hastings, 1992).

Conflict due to the ideological expectations of the hospice worker can lead to stress. The hospice philosophy of providing a good death can be demanding in that every patient's idea of what comprises a good death can be different. Attempting to accommodate all ideological preferences can be challenging (Glass & Hastings, 1992).

2.8 BURNOUT

When the stress reaction is activated too often, it can lead to discouragement. This process happens over time as opposed to being instantaneous. Burnout has been described as, "a syndrome of emotional exhaustion, a depersonalisation and reduced personal accomplishment as a result of the chronic emotional strain of working extensively with other human beings, particularly when they are troubled" (Riordan & Saltzer, 1992, p.17). A definition originating from hospice environment (Riordan & Saltzer, 1992) presents burnout as a coping mechanism used by the hospice workers to distance themselves emotionally from the patient so that they can carry on working in the field. This kind of definition views burnout as a state of being, rather than as a process. In contrast, the transactional process of describing burnout presents three stages: the first stage is said to be an imbalance between resources and demand; the second stage is the immediate short-term emotional response to this imbalance; and the third stage consists of a number of changes in attitude and behaviour such as emotional detachment (Riordan & Saltzer, 1992).

Helper stress can manifest in the following ways:

- cognitively - in confusion, difficulty concentrating, recurrent negative images, memory deficits, irrational thoughts, loss of meaning, and perfectionism
- emotionally - in depression, sadness, guilt and self-blame, hopelessness, anxiety, numbness or emptiness, and a feeling of being overwhelmed
- behaviourally - in withdrawal, isolation from family and friends, nightmares, impatience, inappropriate risk-taking, repeated accidents, and moodiness
- and physically - in headaches, self-medications, sleep disruptions, somatic reactions, weight gain or loss, lowered resistance and aches and pains.

It is therefore clear that sometimes there is a price to be paid for commitment to helping (Kottler, 2000).

2.9 COPING WITH HELPER STRESS IN THE HOSPICE SETTING

Although there is a dearth of research on the prevention of burnout amongst hospice caregivers specifically, the evidence that has been presented supports the reduction of internal and external stresses through a staff team approach and self-care (Riordan & Saltzer, 1992). Factors involved in burnout are subjective and have a complex interplay in each individual. Elements that lead to burnout in one person may present only as a minor irritation to another. A self-understanding of needs, motivation and personal factors of hospice volunteers is therefore essential in the prevention of burnout. Burnout prevention in a hospice worker is best approached via a phenomenological scheme in which the individual differences are incorporated into any preventative programme. Due to this subjective construct of burnout it makes sense to make use of self reports and case studies in research into this area as they may be of more value than statistical results (Riordan & Saltzer, 1992).

2.9.1 Self-knowledge

To combat internal stress the development of an internal locus of control is recommended. This requires all hospice workers to accept responsibility for choosing this kind of work and to acknowledge the reasons for their choice. Do the reasons include unresolved personal issues? Are the expectations of accomplishment realistic? Some of the seeds of burnout often arise in how the helping act is entered into and what is brought to it in the form of motives, needs and expectations (Riordan & Saltzer, 1992).

There must be self-awareness of limitations (Riordan & Saltzer, 1992). By acknowledging personal needs, the effect that they have on the actions of the helper is lessened (Dass & Gorman, 1990). Berger (2001) states that the kind of stress relating to the developmental wounds of the counsellor is inevitable. In the case of the hospice volunteer, working with a bereaved client may trigger past bereavement experiences for the volunteer. If this can be modulated the volunteer can empathise more closely with the client. The symptoms however need to become conscious to the counsellor and supported effectively. If this happens, the past trauma can contribute positively to the counselling experience.

2.9.2 Trusting the Process

The ambiguity of never knowing if you helped or not can be stressful (Kottler, 2000). It is often impossible to measure whether or not the counselling situation helped and on what level (Dass & Gorman, 1990). This lack of feedback gives room for second-guessing (Kottler, 2000). As the self is used in the helping process, involvement becomes more personal. One can deduce that it is not just a skill that was lacking if no change occurs. It also has to be asked if the helper was empathic enough, intuitive enough, courageous enough, or innovative enough (Kottler, 2000). This self-doubt creates a pull to be efficient and to find a solution. Sometimes the weight of personal responsibility leads to exhaustion and frustration. The feeling of personal responsibility or the identification on the part of the helper as the final source of the service, may lead to experience of the

range of emotions and responses that have come to be known as burnout (Dass & Gorman, 1990). The final influence that the helper's action had may never be known. With the acceptance of this fact there is also an acceptance that the helper did what he or she could (Dass & Gorman, 1990). Dass and Gorman (1990) suggest that when the helper becomes more trusting of the helping experience itself there is an ability to find new insights in situations.

2.9.3 Establishing Boundaries

Kottler (2000) states that the key for the prevention of stress overload is to find the appropriate balance in helping relationships so as to maintain a suitable distance from clients whilst still exuding warmth towards them. There is also a need for the helper to be able to balance helping others with attending to their own needs (Kottler, 2000). Establishing appropriate boundaries within the helping relationship enable the helper to fulfil other commitments (Dass & Gorman, 1990). The boundaries established within the helping profession, such as the fifty-minute hour, are there to help regulate the helping experience. Professional warmth is a way of keeping distance, and acts as a necessary survival strategy (Dass & Gorman, 1990).

2.9.4 Team Approach

The team approach in hospice work is widely emphasised as it can provide both physical and emotional support. It allows for the flexibility needed to work in an emotionally charged field. The staff support group can provide a place for catharsis, a critical element in facilitating the grieving process. The group can also provide information that promotes knowledge relating to the dying. It can also promote an opportunity to develop new skills of self-awareness (Riordan & Saltzer, 1992).

The most comprehensive stress reduction programme is only effective if the individual is receptive to it (Riordan & Saltzer, 1992). The following suggestions for stress reduction programmes appear most frequently in literature:

Physical

- Maintaining health through adequate rest and then nutrition
- Physical exercise
- Developing body awareness so that areas of tension can be reduced by breathing and stretching exercises

Psychological

- Mental conditioning through meditation
- Keeping a daily journal to develop and maintain awareness of thoughts that can affect work performance
- The use of a professional therapist to assist in the processing of intense feelings associated with death and grief

Intellectual

- Keeping up with current information in the field of thanatology
- Awareness of the need to improve personal skills in communication and assertiveness
- Maintaining humour is helpful as laughter is a stress reducer

Spiritual

- Balancing the pain associated with loss by emphasising joy
- Religious beliefs can provide comfort through religious practices or belief systems
- A programme to complete unfinished business can provide forgiveness of self and others when needed (Riordan & Saltzer, 1992).

Riordan and Saltzer, (1992) present the following practical suggestions for alleviating the stressors within the hospice setting:

- facilitate grieving and closure by a providing time to attend funerals and memorials

- schedule opportunities for retreats to build staff cohesiveness and a team support
- allow for adequate vacation time for individual nurturance and renewal
- provide weekly support group meetings
- encourage open communication between staff and administration
- give a consistent supervisory support
- arrange for proper orientation and ongoing in-service education
- be aware of the compatibility of the workers personality with the demands of the speciality
- create a staff team approach to work.

2.9.5 Voices of Those in the Helping Role

To be of service to others the self must be faced including needs, doubts and resistances. For helping to be effective we have to remember who we are behind the role. Self-acknowledgement starts with a simple reflection of being uncomfortable in the presence of suffering. As we acknowledge the tendencies within ourselves and look at our defences against suffering we can then see where they come from and how we build them up out of past experience. In so doing we face our own suffering. Through the examination of the link between our own reaction to pain and the quality of our empathy for others, the compassionate response becomes more accurate and more natural (Dass & Gorman, 1990). The following citation illustrates how self-knowledge and acknowledgement of personal needs and responses to pain can lessen the influence they have on the helper. Through self-understanding the following helper's perception of others was no longer coloured by his reaction to the experience. His understanding of other people's perception became more accurate.

“My first visit to India included a stop at Benares. In the streets there were hundreds, perhaps thousands, of people with begging bowls in the final stages of one illness or another and seemed to

be just waiting to die. My heart was deeply pained by the scene. I put lots of change in lots of begging bowls, but even then it didn't seem like enough. In encounters with these people I usually averted my eyes from theirs. I guess I felt guilty that I had so much and they had so little. Finally I was remaining in the hotel rather than face such massive suffering.

By the time of my next visit to the city many months later, I had become familiar with the Hindu culture. I now realised that Benares was one of the most sacred cities in India, situated on the banks of the Ganges, the most sacred river. I also had come to know that in this culture, which believed so deeply in reincarnation, the most auspicious place to die was in Benares. To be cremated there on the riverbank assured liberation after death. Now as I placed coins in begging bowls I was able to look into the eyes of the people. And to my profound amazement I found in their eyes not the suffering that I had been reticent to face, but looks of peace. In fact I even saw in some of their eyes pity for me, lost as I was in illusion. Leprosy, leukaemia, blindness, such poverty that they had only a loincloth and begging bowl... and still...peace. How wrong I'd been to assume that they were suffering, as I would have been suffering in a similar situation" (Dass & Gorman, 1990, p. 73).

In suffering our hearts go out to people, not only because of their immediate circumstances but we recognise the response of mental suffering that we ourselves would experience in the situation. Their predicament awakens our own fears of pain or loss of control. As we understand our own suffering we become available at a deeper level to those we would care for. We are less likely to project suffering and deny that it exists, thereby becoming more sensitive to the pain of others (Dass & Gorman, 1990).

The individual and subjective nature of factors that lead to stress and a display of self-knowledge of these factors are illustrated in the following quote. A male nurse working in a hospital with AIDS patients, when questioned as to the impact this work has had on him, says:

“I have stepped back tremendously within the health care in the gay and lesbian community since I moved to Houston, because I’m tired. One of the things that personally happened with me is a strain that results in getting patients with whom you can readily identify. I’m 38. The same age as many of these patients. I’m outgoing. I’ve had a large number of patients who are very responsible, and when these patients die its very hard. I find it much more of a loss. I’ve just had a professional relationship with them, and yet I find it much more of a loss. I think it brings to mind my own immortality” (Henderson Baumgartner, 1985, p. 63).

When asked how he handles stress:

“I have to get away as often as I can. A large segment of the end part of our training weekend deals with burnout. It creeps up on you. You can’t totally prevent it. I have to keep telling myself and my friends have to keep telling me that this is my job now, and at times I have to get away and leave it. Also I have a fairly good support system, and that helps” (Henderson Baumgartner, 1985, p.67).

This illustrates the helper’s balance in also attending to his own needs (Kottler, 2000).

2.10 TOWARDS AN INTEGRATION OF THE VOLUNTEER'S EXPERIENCE

From the above it can be seen that many different aspects of the helping role and the volunteer role have been examined. In contrast to focusing on the different aspects of volunteerism as separate entities, Uffman (1993), in a qualitative study carried out in California, examined the motivations, expectations, dreams, fears and day to day lives of hospice volunteers. The volunteers spoke of the rewards and difficulties of their experiences and these were often intertwined. Amongst the rewards most frequently cited were those of feeling appreciated, making a difference, achieving a close connection with patients and their families, and being part of a supportive team. Kottler (2000) echoes the way in which difficulties and rewards are intertwined. He states that the intimacy that takes place in the helping encounter is quite unlike any other relationship. It is both exhilarating and frightening. Trying to work as a team can be stressful (Glass & Hastings, 1992), yet it is also cited as rewarding (Uffman, 1993; Payne, 2001). Each aspect of helping seems to have the potential to have both a negative and a positive impact on the lives of the volunteer.

2.11 DEATH ATTITUDES

2.11.1 How They are Affected By Life Factors

It is important to have an individualised approach when studying the impact of life factors on death attitudes. However, research results in this area have been contradictory or inconclusive. Research proceeded according to the assumption that life experiences possess common features and as such have a uniform effect on individuals, either positive or negative in nature, on death attitudes. The contradictory and inconclusive research results would seem not to support this assumption. Franke and Dulack (1990) compared death attitudes of respondents depending on whether or not they have experienced the death of a significant other, have had a near-death experience, or attended classes or workshops on death and dying. It seems that the impact on these experiences differs from individual to individual. For example the experience of the death of a significant other varies in its effects depending on the individual's relationship with the dying

person, the circumstances surrounding the death itself, and events preceding and following the death. It was concluded that life factors affecting death attitudes are complex and are best served by research studying the totality of death related factors for each individual by documenting the effects of each factor. Research design that does not provide an individual level of analysis will obscure the potentially unique effects of each death related factor (Franke & Durlak, 1990).

2.11.2 Death Attitudes and Relating to the Dying

Cochrane (1990) found that oncologists with low death anxiety scores related more effectively to dying patients compared to those with high death anxiety scores. Oncologists who did not disclose terminal status to dying patients reported problems with disclosure, tried to avoid direct disclosure and were not as comfortable with dying patients compared to others patients. Short term repeated exposure leads to comfort with dying patients while long term repeated exposure led to discomfort.

Hayslip (1986) found that Individuals who express more difficulties in communicating with the dying show that several important aspects influence their ability to relate to persons who are terminally ill; they are less likely to repress fears about their own deaths; are more likely to express concern over their own death or another who is dying and are more likely to have negative attitudes towards ageing and death.

The above research indicates that those who exhibit greater anxiety around death have more difficulty relating to and communicating with the dying. In contrast to this, Momeyer (1985), says that fear of death is not so undesirable as it seems in those who are involved in caring for the dying, in fact, fear of death may be psychologically unavoidable. He claims that it is not possible to render care to the dying without the caregiver candidly and honestly acknowledging their fear of death.

Sandor, Speece, Gates, Mood, & Kaul, (1991) in studying graduate and undergraduate nursing students found that professional experience in working with dying patients helped to decrease aversiveness towards working with the terminally ill.

2.11.3 Hospice Volunteers Attitudes Towards Death

Patchner and Finn (1987) studied specifically hospice volunteers' attitudes towards death. They found that 83% of them believed in a life after death, 7% were uncertain and the remaining 10% had serious doubts about life after death. Only 8% would want to die in hospital while 49% would want to die at home, others were not sure. Almost half, 49%, would tie up loose ends before they died while 18% would make no changes in their life styles, 13% would shift from addressing their own needs to that of others, 4% would engage in new experiences and the remainder would make other types of adjustments. However, 22% reported that they rarely think about their own deaths, 60% occasionally, 16% frequently and 6% very frequently. Only 9% feared death, but 55% feared the pain associated with it.

The low percentage of fear of death in hospice volunteers confirms the studies carried out on different populations by Cochrane (1990) and Hayslip, (1986); those with low death anxiety relate well to the terminally ill.

2.12 HOSPICE AND THE CHANGING FACE OF DEATH

Post-modern is a term used to describe a society where the control has been transposed from those owning and controlling static resources to those who control the flow of information (Kastenbaum, 1993). Western society is classified as a post-modern society in that media and the flow of information has a large influence and control on the way individuals think. Our post-modern society has a death system that mediates our relationship with death, involving such things as specific roles, places, objects, symbols and times (Kastenbaum, 1993).

Fear of death in society is evidenced by the way which it has been culturally banished and psychologically denied (Rinaldi & Kearl, 1990). Even thanatology, with its focus on the dreaded subject of death operates within established social values and practices as it distracts itself from the dead body and the physical realities of death by replacing these concepts with words and symbols. Stage theories owe much to this same need in that the stages provide not only a guide to the anxious visitor or caregiver, but serve to distract those involved from the physical side of dying. The focus is on the different psychological stages associated with death as a distraction from the physical process. Negative physical changes are ignored (Kastenbaum, 1993).

Illustrating this trend to deny the physical reality of death, sociologists Umberson and Henderson (1992) examined the social construction of death during the Gulf War. Stories appearing in the New York Times displayed an apparent lack of direct references to death. The words 'death', 'die' and 'kill' were not used and were replaced by euphemisms such as casualty and loss. The same words were used when referring to the destruction of people as were used to refer to the destruction of equipment and buildings. None of the euphemisms explicitly refer to human injury or destruction, which according to Umberson and Henderson (1992) serve to dehumanise the victims of war. Clearly, society has not provided the necessary framework with which to deal with death.

Western society's medicalisation of death has resulted in loss of individual control over the dying process. Hospitals focus on life saving and death is perceived as a failure by the staff. The family often gets angry and feels betrayed at the outcome of dying. The patient is put through every known treatment programme, often at great expense and added suffering. The emphasis on technological death gives physicians total control of the final rite of passage. The dying patient lacks the knowledge and power to make their own decisions. Loss of control is seen as a loss of dignity. The very meaning of life in

the form of conscious self-control and decision-making is taken away (Rinaldi & Kearn, 1990).

As hospital costs soar and high technology replaces the personal, human touch, death concepts other than those currently available must be explored (Basile & Stone, 1986). The concern becomes more pressing as the average age of death increases and a larger proportion of deaths are related to chronic illness. Death is a major event for which society has not taught us effective role behaviour, either as caregivers or patients. The hospice concept has emerged as a result of this need (Basile & Stone, 1986).

Kastenbaum (1993) states that our post-modern society has a changing relationship with death and associated ideas on death are headed in a different direction. These wavering images of death are likely to be transformed by the patterns of the modes of death experienced. Thanatology, a new influence in this sphere, has sensitised people to the universal human plight of the dying and the grieving even though it has accepted society's choice to de-emphasise the physical aspects and fundamental nature of death (Kasterbaum, 1993). Kubler-Ross' writings, despite her emphasis on stages and de-emphasis of the physical process of dying, was a reaction to the quality of death within a culture and climate of denial (Kasterbaum, 1993). Hospice is said (Rinaldi & Kearn, 1990) to be a reaction against an atmosphere that does not allow the patient to express his real feelings about dying and living until death. Hospice fights the taboo against death (Rinaldi & Kearn, 1990).

Hospice programmes represent thanatology at its best. Society's resources and values are integrated; claims for specialised knowledge, social feeling and uniqueness of individuals are not at war within these programmes. All participants share a sense of common purpose offering solidarity and togetherness as protection in facing mortality (Kasterbaum, 1993). Successful programmes require the co-ordinated efforts of an integrated society. They also

further society in its rediscovery of the potential to actualise its own values. The most profound of society's values that hospice actualises, is that of not retreating from death and loss but accompanying the dying person to the border of death, and staying with them as long as they are part of the community. Hospice demonstrates the forces that bind person to person when faced with loss, dissolution and lack of control (Kastenbaum, 1993).

People in western society have difficulty thinking about death, as it is associated with various modes of dying such as war, murder, and suicide. Hospice care and a more enlightened public attitude are working to change these images of death and those associated with illnesses such as cancer. Today cancer does not always mean death. Nor does a cancer-related death necessarily conjure up images of severe pain, anxiety, social isolation and shame. Cancer had become the emblem of death in our society, but now it is possible to live and die with cancer a little more 'safely'. Death has been revised a little more closely to the heart's desire (Kasterbaum 1993).

Two hospice workers see the emergence of the Hospice movement as follows:

“(Hospice) seems a move toward acceptance of death as a natural part of the life cycle in a culture which has more and more denied the reality that we are mortal” (Rinaldi & Kearn, p. 291, 1990).

Yes, I believe the Hospice movement has come about as a reaction to the impersonal deaths that have occurred in institutional settings. For years the dying were set aside, almost neglected since the medical professionals thought that there was no reason to put time and caring into a person they had no hope of cure for. Society as a whole wasn't able to talk about, let alone deal with, the dying” (Rinaldi & Kearn, 1990, p. 291).

Hospice is changing society's experience and images of death (Kasterbaum, 1993) and providing the necessary context to teach us effective role behaviour (Basile & Stone, 1986).

2.13 CONCLUSION

This study will follow the qualitative paradigm in that I will work inductively. The themes described in the following chapters emerged from the participants' experience and were gleaned from interviews held with them. The themes were not specified in advance or based on the above review of literature.

The social science theories reviewed in this chapter are used to compare the themes that emerge from the interviews with this current literature to establish where they are similar and where they differ for this specific sub-group of helpers, namely hospice volunteers. They are used to confront the data only after the themes have been extracted. However, the literature was used to establish the focus of the study as it influenced some of the questions posed in the interviews.

The study seeks to explore the experiences of hospice volunteers as opposed to positioning the study within a theoretical camp (Creswell, 1997). The method used to gather and analyse the data will be explained in the following chapter.