

CARE FOR THE CAREGIVER:
ADDRESSING THE ISSUES OF PALLIATIVE
CARE PROVIDERS

by

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The purpose of this study was to explore the experience of health care professionals working in a palliative care unit, who participated in a brief, client centered counselling intervention. Eight health care professionals, representing both the nursing and allied workers, received between six to twenty individual counselling sessions with a counselling psychologist. This study utilized a phenomenologically based, qualitative approach to investigate participants' experience of the counselling sessions and their perspectives on its impact in their work and personal lives over a six month period. Participants' interpretations were grouped into nine themes: Expectations of counselling, if and how expectations were met, areas of stress in the workplace, enabling factors for participants to attend counselling, main issue addressed in counselling, changes in personal or home life, changes in work environment and interactions with colleagues, changes in job satisfaction and performance, and additional comments regarding the counselling experience. Results indicated that most participants reported positive changes occurring intrapersonally, interpersonally, and in their levels of job satisfaction and job performance. Since this approach appears to merit further attention, implications for practice and further research are discussed.

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Chapter I

Introduction

Context

As we seek to understand the effects of human loss and to unearth resources to triumph over it, we are continually made aware of our own unresolved and still painful feelings of past losses and traumas. It is in acknowledging these together that we create that sharing, supporting community which can continue to be alongside our patients and families in sickness and anxiety, in despair and hope, and through bereavement. (Earnshaw-Smith, 1988, p.12)

"Caring for the dying brings situations of personal crisis" (Rando, 1984) and takes a toll on those who provide the care. Often those close to the dying person are health care professionals working in a hospice environment who may also experience bereavement as the patient they have been caring for dies (Fisher, 1996).

Much emphasis has been placed on how to effectively aid the patients who are dying and their family members in dealing with issues of grief and bereavement (Vachon, 1998). However, very little consideration is given to those health care professionals who have to adjust to working with the dying. Rando (1984) states that while hospital organizations

that devote themselves to the care and comfort of the dying claim to recognize the emotional needs of their staff, there is rarely a translation of this recognition into policies "that assist caregivers to continue to cope with the stress of their positions in the most healthy ways possible" (p. 438).

Caregivers are aware that the end result for patients entering a palliative care ward will be death. As opposed to other health care professionals who are not involved with the terminally ill, palliative caregivers must view success within their workplace from a different perspective. "The measure of effectiveness must lie in the process of exchange between the professional and the patient and the possible successes along the way" (Clark, 1989, p. 239). Personal relationships are the essence of palliative care and involve intense emotional connection between the caregiver and the patient. A major concern that is often not specifically addressed is the extreme loss that the caregiver suffers when the patient dies.

Sneidman (1978) emphasizes that "working intensely with a dying person is different from almost any other human encounter" (p. 206). Human beings have the capacity to make

connections between past events and experiences to current situations. This is often the case when it comes to the multiple losses experienced by palliative care providers. Patient deaths can lead to caregivers recalling unresolved issues from their past which may affect their ability to successfully cope with personal or work issues. "Hospice personnel and others who work with the terminally ill have been successful in meeting the needs of the patients - but often at their own expense" (Riordan & Saltzer, 1992, p. 17).

Weisman (1987) believes that for the caregiver, "altruism begins at home: taking personal care is a personal obligation toward oneself" (p. xii). Before individuals can address the issues of the terminally ill patient, they must be able to take care of their own well being and have significant, effective coping mechanisms in place. Health care training and education prepares health care professionals to be efficient, skillful and competent in providing medical comfort and care. However, these skills are not sufficient when individuals are working with the terminally ill patient. They must also have well-developed interpersonal skills and emotional stress management skills

because, "their own emotions are exposed during the adaptation and adjustment period" (Harper, 1993, p. 185) to the palliative work environment.

Terminal illness and death are traumas that can trigger deep, emotional anxieties for the caregiver. To provide complete, effective care of palliative patients, the health care professional is required to:

1. Understand the dynamics of behaviour of the patients who will not recover.
2. Relate to the actions and reactions of the relatives.
3. Give care, counselling, support, and strength to patients and members of the family.
4. Understand and deal with their own feelings and anxieties. (p. 186)

Without the ability to "understand and deal with their own feelings and anxieties", the caregiver places themselves at risk for heightened stress levels and possible worker burnout. (Vachon, 1988).

Vachon (1987) in a large scale survey of over 3,000 nurses found that "76% reported feeling depressed either

almost always or occasionally when caring for an incurable, terminally ill patient" (p. 155). Feelings of depression, anxiety, and fears surrounding death and loss frequently affect the palliative caregiver. A review of the literature suggests team support and supervisor awareness as tools to aid caregivers in coping with these emotions. However, there is a paucity of research within this literature about the effectiveness of such techniques. Additionally, there is a lack of information on the effectiveness of counselling interventions when working with health care professionals on workplace traumas.

Harper (1993) suggests that health care professionals must each individually "learn to cope with their anxieties arising from the caregiver experience" and be granted time to adapt to their work situation and work through "their feelings about death, dying and the in-between process" (p. 188). A review of the literature finds similar sentiments and an emphasis on not allowing health care professionals to suffer psychologically as a result of their work with the terminally ill. What is lacking in this body of material is any proven technique or intervention that would provide these caregivers with the opportunity to master these coping

skills.

Purpose of the Study

The purpose of this study is to provide an initial, participant-driven evaluation of the impact of a counselling intervention on caregivers on a Palliative Care Ward. The counselling consultant employed a client-centered, Egan model approach.

The literature related to caregiver stress, burnout and alternate coping techniques is surveyed as a backdrop for the present investigation. It is the hope of the researcher that this study will provide an initial understanding of the potential benefits, risks and limitations of utilizing a counselling intervention with palliative care workers. Results of this study will be used to assess the value of this intervention. In addition, the results will be accessed as a resource for designing possible future interventions with caregivers that work in hospice environments. This study is significant in that it seeks to address the improvement of coping mechanisms used by caregivers in dealing with the often traumatic environment of palliative care.

Research Approach

As this research study is seeking to evaluate the effectiveness of the counselling intervention, it is essential to consider who is best suited to be the judge and evaluator. Guba and Lincoln (1993) state that evaluation, to be considered complete and sound, must consider the view and values of as many stakeholders as possible. This study elicits the experiences of the service recipients, the employees on a Palliative Care Ward. The counselling consultant, physicians and male caregivers did not select to participate in the study. This may limit the range for utilizing the counselling intervention and increases the necessity of a follow-up investigation. The research questions posed are, 'if they have experienced any personal or work related changes as a result of the counselling intervention; how successful was this intervention from their perspective'.

In order to receive a rich, full body of feedback, a qualitative approach was utilized with the primary data source being the caregivers themselves. No quantitative measures were used in this study. Caregivers were interviewed to draw out their personal stories and

perspectives on the experience of the counselling intervention. Future investigations of this intervention may well require a combination of quantitative and qualitative research approaches. The researcher hopes that the data presented in this study will be the basis for such future work. The implications of the research data on the counselling intervention will be discussed. However, readers will be left to arrive at their own conclusions as to the success of such a technique for future use.

Chapter II

Literature Review

Stage Theories and Dealing with the Issue of Death

Even brief reviews of the literature dealing with death will reveal a structured and stage-driven approach to the issue of how human beings deal with the concept of death and dying. Elisabeth Kubler-Ross (1969), considered a pioneer in death and dying, discusses six main stages of coming to terms with death and dying: denial, bargaining, anger, despair, resignation, and acceptance. Along with these stages of coping with death and dying that apply to the general human population, Kubler-Ross mentions specific difficulties faced by those individuals that work with terminally ill patients. She states that the process of working with the dying involved the caregivers reliving feelings of loss from their own lives and that there is an "obvious parallel" between the reactions human beings have to their own death and that of another person.

Price and Murphy (1984) describe specific stage theories that have been developed to apply to those professionals who work with dying individuals. The first

stage of shock and disorganization considers palliative work to be an "assault on [the worker's] sensibilities" (p.52). To be working in an environment where patients never return to a healthy state challenges basic medical beliefs and personal goals for health professionals (Harper, 1993). Death becomes an issue on a personal level as well and the health care professionals are challenged to face their fears and expectations around their own mortality (Kubler-Ross, 1969).

The second stage is volatile emotions. As the grieving process progresses, it is important to be able to express the emotions that arise as a result of the experienced loss (Kubler-Ross, 1969). Price and Murphy (1984) believe that caregivers often fail to release their emotional reactions due to being "good givers" who are reluctant to display emotions and challenge their social conditioning. The health care professional begins to grieve their own mortality that they faced in the first stage (Harper, 1993).

The third stage, guilt, can be an area where caregivers that work with the terminally ill can become stuck (Marshall & Kasman, 1980). Each time a patient dies, caregivers will often engage in a process of reviewing the care they

provided to this patient. Price and Murphy (1984) state that rarely can such a review take place without some feelings of shame, culpability and guilt. While we can accept that in many ways, feelings of guilt that accompany loss do not reflect actual culpability, real guilt may remain. It is this "unexamined pseudo-guilt and unforgiven real guilt [that] are among the most destructive factors in the stress syndrome that so often, and so wastefully, result in staff burnout." (p. 54).

The fourth stage of loneliness addresses the feelings of isolation which occur when caregivers are overwhelmed by "loss-related stress" (p.55) even though they are surrounded by caring colleagues (Harper, 1993). Marshall and Kasman (1980) state that loneliness does not necessarily lead to staff burnout and instead, if constant and consistent support is available, personal and professional growth rather than collapse can be the outcome. Harper (1993) states that this stage is referred to as the "grow or go" period where the health care professional must "accept what they will do or shall do about working with terminally ill patients. If they are still in the 'shall' mode, then there is a possibility of those individuals leaving the job". (p.

192).

The fifth stage is relief. This is the first step to recovery and in this stage there are feelings of pride and pleasure in achievement as the caregiver realizes that they have 'survived' the acute phase of their grief (Price & Murphy, 1984). Harper (1993) asserts that in this stage the health care professional is now "free from the constant and deep-seated emotional concern about his or her own death and dying" (p. 193). Identification with patients is limited and there is no longer a need amongst the professionals to "imagine or feel that they, too, may be suffering from the same illness as their patient" (p. 193). This stage leads to a more solid grounding and growth both personally and professionally.

Price and Murphy (1984) believe that once one's emotional equilibrium is disrupted due to a stressful event, the reestablished balance point is never the same as it was prior to the event; "there is a new reality within the organism, as well as in the environment" (p. 56). Not only is the individual strengthened in their ability to cope, the workplace has been strengthened through the success of a team member. Harper (1993) believes that the deep compassion

felt by the health care professional for the terminally ill patient is able to be translated, in this stage, into "constructive and appropriate activities based on a human and professional assessment of the needs of the patient" (p. 194).

Some of the limitations of using stage theories are that, as previously alluded to, they seem to imply a regular, if not inexorable, "progression through neatly defined steps and as such [they do not] accurately describe the often messy, even seemingly chaotic, character of mourning behaviour" (Price & Murphy, 1984, p. 51). Stage theories, overall, are unable to account for the idiosyncratic nature of human behaviour and the fact that "human personality develops according to steps predetermined in the growing person's readiness to be driven forward" (Harper, 1993, p. 187). However, Kubler-Ross states that the stages are not rigid in nature but flexible as the grieving individual will fluctuate back and forth between stages many times in the course of the mourning process.

Death and Identification with Patients

"Death is still a fearful, frightening happening, and

the fear of death is a universal fear even if we think we have mastered it on many levels. What has changed is our way of coping and dealing with death and dying and our dying patients" (Kubler-Ross, 1969, p. 19). Health care providers are ultimately no different from any other human being in that we are mortal beings and our existence is ephemeral in nature. In her study of nursing staffs on Palliative Care Wards in France, DeHennezel (1989) found that palliative care workers are intricately intertwined with death and must deal with it on several levels:

Socialization of the dying process implies recognition of its value, not denial. But what demands does this place on the staff? They must: enter into a relationship with the patient; participate in the exchange required by the dying process; be able to talk about and exchange their own conception of death and the process of dying, so as to identify the yardsticks, the markers which will help them to conceptualize their own practice; and accept being changed, because merely to manage the death crisis without letting oneself be transformed by it would block the dynamics of the process. (p. 31)

As there is an implicit requirement to remain present with the dying process of the patient, there is also a functional responsibility to come to grips with one's own concerns about death in order to be effective in working with

terminally ill patients (Feifel, 1973). This requirement applies to all professionals who work with dying patients. Josef (1980) asserts that counsellors who work with individuals who are facing death "must be personally prepared to manage the powerful, and sometimes irrational forces that will tear at them" (p. 127). This means that the bereavement counsellor must have a commitment to developing a deep understanding and acceptance of death as a necessary aspect of life. Health care professionals working with the terminally ill must also face their own mortality in order to maintain high levels of job performance (Benoliel, 1988).

Benoliel further states that addressing the issue of death with patients and families continues to be a challenge for health care providers. The delivery of effective and personalized care for terminally ill patients is "impossible when providers are unwilling or unable to engage in open communication with patients and families" (p. 345). Kubler-Ross (1969) wonders if the technological developments of modern medicine are not simply an avoidance of the "suffering face of another human being, that which would remind us once more of our lack of omnipotence, our own limits and failures, and last but not least perhaps our own

mortality" (p. 23).

Present loss resurrects unresolved past loss according to Rando (1984) and many of the caregiver's own feelings, thoughts, memories and fantasies about loss-related experiences in their own personal life are brought forward by the impending death of a patient. From one death to the next, caregivers are subjected to a multiplicity of mournings that "have left open wounds or have simply never been thoroughly carried out" (Marquis, 1993, p. 26). Marquis states that each occurrence of death regresses each individual to "the experience of his previous confrontations with death. There can then take place a reactivation of past mournings and the individual is referred to his ability to carry out a labor of death" (p. 26). This labor is the therapeutic process where the individual struggles with his/her own accumulated grief until the sorrow 'wounds' from the past are healed.

Rando (1984) reinforces this opinion further in stating her belief that unresolved issues from the individual's past cannot help but be relived until there is a point of acceptance on the part of the individual of the death(s). Plante and Bouchard (1995) in their study of nurses working

in palliative care settings found that their subjects often felt frustrated and powerless when dealing with the finality of death. They stated that as nurses are "so close to human suffering, [they] are confronted with their own emotions, their own death and death of their beloved" (p. 94). Marquis (1993) found that many health care professionals who work with the terminally ill "nourished the secret hope of possessing within themselves the magical word or gesture" that would provide victory over death and would prevent another mourning opportunity. This 'magical' thinking strategy for coping with dying patients is not uncommon in the palliative environment (Benoliel, 1988).

Vachon (1987) found that being surrounded by death in the workplace, palliative care workers often became unable to plan for their futures due to a sense that "one couldn't invest in life -- illness, death or disaster could occur at any time" (p. 155). Field (1998) found in a study of general practitioners that 43% described difficulty coping with their own emotional responses to dying patients and would likely withdraw and reduce contact. Both of these coping responses suggest an inability to resolve personal issues of death and as a result, personal life satisfaction and job

performance are compromised.

DeHennezel (1989) wonders if these responses to the death of a patient are not the result of health care professionals beginning to view death as a "disappearance" (p. 31) where the anxiety that lies around the death involves the feeling that it was all for nothing, a death which caused no change around it. Vachon (1987) reiterates this belief and states that the anxiety of the disappearance is rooted in the personal identification of a health care professional with a patient.

Identification involves the psychological concept of counter-transference in which "the conscious or unconscious emotional reaction of the [professional] to the patient may interfere with [therapy] (Osol, 1972, p. 372). Vachon (1987) believes that certain patients are more apt to evoke these responses in health professionals: "children, young people, or those who will be leaving young families; intelligent and cooperative patients; those who are similar in age, social class, or lifestyle of the caregiver" (p. 104). Foster and Davidson (1995) state that there is a strong link between patient identification and fear of death for social workers in a palliative care setting. "Workers report on the

difficulty of watching the patient deterioration and death and they are troubled by sharp awareness of their identification with their clients" (p. 294). Vachon (1987) confirms these findings in her study of nurses on palliative care wards. The nurses reported that the single greatest stressor in their work environment was identification with patients and their families. Plante and Bouchard (1995) describe nurses as needing a significantly longer period of time to grieve both patients and families that they identified with once the patient has died.

When nurses identify with terminally ill patients and are unable to express feelings of loss around the impending death of these patients, Vachon (1978) found that the quality of care for the patient decreased and other helping professionals were relied upon to fill in the care gap. This withdrawal of care, as discussed previously, ultimately harms the caregiver as they review their care of the patient once he or she has passed away (Vachon, 1987). This increases the level of caregiver stress and undermines his/her identity as a caring individual.

Vachon states that often caregivers will over-invest in patients to compensate for a lack of validation of their own

worth as human beings. The loss that is experienced when these patients pass on is a major psychological threat to the caregiver's feelings of personal worth and professional competence. Without other ways of maintaining role and personal identity, the over-invested caregiver is at risk to move from grief into depression with the death of the identified patient.

Grief & Loss

Grief refers to the process which, over an unspecified length of time, embraces a range of internal states and behaviours, some of which are quite separate from crying and overt sadness (Price, 1984, p. 49). Grieving is not a static event. It is a fluid state that is intricately linked to emotional loss. When human beings are confronted with loss through death, they "often feel as though part of his or her own self has also died" (Corazzini, 1980, p. 73). During the grieving period, the mourner experiences periods of inertia, unable to establish new goals or commitments or move past old ones. Reviews of the literature suggest that bereaved individuals have certain emotional and psychological reactions to loss including: shock, denial, anger, guilt,

loneliness, restlessness and questioning the meaning of existence (Ferguson, 1989).

Vachon (1987) adds that grief can often be the initial stage of a "full blown depression" (p. 154). Symptomology similar to depression is seen in the grieving individual: sleep and appetite changes, intense sadness and fatigue, and guilt for instance. However, Vachon states that the missing link between grief and depression is "the loss of self-esteem found in most depressions" (p. 154). Worden (1982) affirms this and adds that people who are experiencing periods of loss do not view themselves as less. Instead, there is concern about the guilt that the individual may feel around the loss. This is not guilt associated with a feeling of overall culpability for the loss, rather it is "usually guilt associated with some specific aspect of the loss" (p. 28).

Vachon (1988) specifies that caregivers are prone to feelings of loss but are not limited to experiencing loss only through the death of patients. Caregivers also grieve in response to loss of support from colleagues, loss of self-esteem due to unsatisfactory job performance or a lack of support from the caregiver team. She states that, in

particular, caregivers who "are very invested in their professional role and lack outside validation of their self worth may be particularly vulnerable to feelings of grief and depression" (p. 156). In Vachon's (1987) study of palliative care nurses, she asserts that the individual meaning that human beings ascribe to each particular loss, on a conscious or unconscious level, will be the determining factor on whether or not there is a grieving response.

Raphael (1980) stresses the importance of caregivers increasing their sense of self-awareness around issues of grief and loss. Health care professionals that deal specifically with terminally ill patients are subjected to experiences that require them to feel and deal with loss. Rando (1984) believes that "whenever we lose something or someone in whom we have invested ourselves emotionally, we have a need for a grief response" (p. 430). Not only must the grief response be present for caregivers, it must be accompanied by an appropriate amount of time to adjust to the deaths with "ample opportunities to do their own necessary grief work" (Harper, 1993, p. 196). Without the ability to fully grieve emotionally laden deaths, the caregiver's "professional behaviour may become cold and

callous" (p. 196).

On palliative care wards, the time that is required to release the attachment a caregiver has for a recently deceased patient is limited by the demanding needs of another dying individual (Marquis, 1993). Although new relationships may compensate for the sorrow and loss experienced by the ending of a previous relationship, they will "end in separation as well and the necessity of mourning" (p. 27) will continue for the palliative care worker. Marquis indicates that this cycle can lead to a state of exhaustion that will cause the health care professional to "cool down their relationships, converse little, isolate themselves, and hope that [by] behaving in this manner they will avoid having to untie themselves further" (p. 27). Each detachment will progressively lead to de-investment in the palliative process.

Failure to grieve each individual loss can be extremely detrimental to the personal and professional worlds of the palliative care provider (Rando, 1984). The factors that often lead to this failure include: the social negation of loss, as the "loss of a patient is not usually defined as an appropriate loss to be grieved" (p. 431); social isolation

from support systems within the hospice system; ambivalence and guilt towards the loss, which often conflicts with role identity to both cure the individual and hope for the end of their suffering; and a feeling of "being overwhelmed by multiple loss" (p. 431) which leads to the previously mentioned cycle that terminates in caregiver withdrawal.

Similar to palliative caregivers, bereavement counsellors suffer a heavy personal toll through their work with the terminally ill (Corazzini, 1980). Each loss that these professionals encounter elicits an emotional response from the counsellors and "they experience their losses over and over again" and "become especially vulnerable" (p. 79) to symptoms of professional evacuation from the intensity of each work situation. Without being able to grieve each loss in a full and meaningful manner, the bereavement counsellor constricts his/her emotional availability to clients and cannot provide the necessary environment for terminally ill clients to openly encounter their own mortality.

Along with the professional caregiver who has experienced multiple losses without resolution, the family members of the terminally ill patient will also often move to a position of withdrawal. Rando (1984) states that this

leaves the caregiver in an environment that adds additional liabilities to their occupation. Caregivers, in this abandoned environment for the patient, will develop into "surrogate grievers" for the patient. In this position, the caregiver "comes to grieve almost as much, if not more, than the family member" (Vachon, 1987). Fulton (1979) believes that societal difficulty with death, the lack of family cohesion or absence of family due to distance puts the caregiver in the dual-relationship of providing medical and emotional / social support for their patients. "This results in caregivers taking emotional risks and forming bonds that will require a grief response when terminated by death" (Rando, 1984, p. 430). The danger of these overly-involved relationships is that the caregiver can become completely incapacitated by grief and anticipatory loss which may prohibit them from actually participating further in the care of the dying individual (Vachon, 1987).

To avoid the reduction in competency of the palliative care provider, Lane (1994) declares the essential nature of care and support for the caregiver. "How well an individual works through loss depends, in part, on the available support system in the immediate environment" (p. 306).

Raphael (1980), too, advocates for the caregiver to become involved in continuing support systems to address the multiple losses they confront on a daily basis. In this way, there is a stabilizing force for the caregiving individual that will allow them to deal with personal and work-related issues and crises.

Staff Burnout

Maslach and Jackson, who pioneered the research on worker burnout, provide the definition of burnout as: "a syndrome of emotional exhaustion and cynicism that frequently occur among individuals who do 'people work' -- spending considerable time in close encounters with others under conditions of chronic tension and stress" (Clark, 1989, p. 237). Clearly this describes the situation of many caregivers involved in palliative care environments. The work conditions alone, apart from all other stressors, can predispose these health care professionals to burnout (Rando, 1984).

Riordan and Saltzer (1992) provide a hospice definition of staff burnout. They describe it as a "coping mechanism used by staff members to distance themselves from the

patient emotionally, thus enabling them to continue working in the field" (p. 17). Price and Murphy (1984) link burnout to job performance by stating that the stressful work environment of palliative care workers finally overwhelms "the defenses of some staff members, forcing their physical or emotional withdrawal" (p. 47) from the hospice setting.

Arvay (1996) asserts that there is a substantial link between the themes found in burnout literature and the symptoms of traumatic stress. McCann and Pearlman (1990) found that symptoms of burnout may be comparable to the numbing and avoidance patterns witnessed in survivors of traumatic experiences. Arvay's study on counsellor stress revealed burned-out therapists "obsessing about [their] client, having repetitive nightmares, withdrawing from other clients and family members, [and] involvement in minor deviations from professional behaviour or blurring therapeutic boundaries" (p. 194). This description is very similar to the experience of palliative care providers (Riordan and Saltzer, 1992; Rando, 1984; Vachon, 1987; Vachon, 1988).

Health care professionals have been identified as being particularly vulnerable to burnout, particularly those who

work in hospital settings with seriously ill patients (Clark, 1989). Vachon (1979) specifies that hospice and palliative care professionals are also at high risk for burnout. The major identifying characteristic these groups share with regard to burnout is their constant and close proximity to death and grief in the workplace environment (Clark, 1989). In her study of 'battle-fatigue' on palliative care wards, Vachon (1988) found that hospice/palliative care workers are "more vulnerable to battle fatigue or burnout than other caregivers to the critically ill, dying and bereaved" (p. 150). The multiple roles of the health care professional in the palliative care setting lend themselves to greater involvement and attachment to the patients and therefore put these professionals at an extreme risk for burnout.

Plante and Bouchard (1995) discovered a significant, positive correlation between occupational stress and burnout for nurses working a terminally ill population. Furthermore, they found that, "the stressors linked to the working environment had the highest correlation with burnout" (p. 101). Vachon (1986) supports this result and finds that the work environment is more often responsible for occasions of

burnout than the physical and emotional status of both the cared for patient and their family. Clark (1989) believes that a primary cause of burnout for health care providers working with the terminally ill lies in feelings of powerlessness and failure. Internalization of such feelings and the resultant personal questioning contribute significantly to the risk of burnout for the caregiver.

Marquis (1993) expands upon the personal questioning that the caregiver undergoes. In an effort to seek a position of equilibrium in their work environment, the palliative care worker, as previously mentioned in this section, will withdraw from emotional connections with patients. However, the caregiver also undermines their role and identity through this withdrawal process:

Believing this solves the problem, instead it only aggravates it. It becomes impossible to find any kind of satisfaction in an occupation involving the helping relationship, if one does not establish contact anymore with those who are helped, if one has ties only with themselves. This isolation can only lead to a more violent rejection of what one believes oneself to be, of one's choices, of one's life, of life. (p.27)

This emphasizes the importance of addressing burnout conditions within the work environment. Logically, if the

caregiver has removed themselves from emotional and even physical contact with the patients within the hospice/palliative setting, they can no longer provide the health care required by this demanding population.

Distancing, as a result of burnout, reduces the caregivers' ability to gain satisfaction from their work and authentic bonds with both patients and co-workers do not exist. Vachon (1988) reinforces this. When caregivers are subjected to burnout conditions or become burned out, it may be "difficult, if not impossible for the worker to continue to perform the functions associated with one's role with dying persons and their families" (p. 149).

Burnout therefore entails loss for the caregiver of their work identity and also threatens their ability to receive support from co-workers (Price & Murphy, 1984). Co-workers are unable to reach their peers and provide them with the "intangible benefits which flow from association with creative, enthusiastic, caring, idealistic, energizing colleagues" (p. 50). While we may assume that the process of reaching out to depleted team members would be a natural response, it is important to note that Vachon (1988) found that the caregiving team "may become threatened and withdraw

from those in need of help" (p. 158). Both individuals and groups are affected by burnout and often cannot adequately address the needs of the withdrawn caregiving member.

Stress

A stressor can be defined as "a demand made by the internal or external environment of an organism that upsets its homeostasis, restoration of which depends on a nonautomatic and not readily available energy-expending action" (Antonovsky, 1979, p.72). Stressors do not necessarily have negative connotations. Many people thrive within stressful situations and a certain degree of stress is required by living organisms to maintain a sense of equilibrium (Vachon, 1987). Antonovsky separates stressors into the two categories of internal and external. For caregivers, an example of an internal stressor might be their personal expectations of being able to heal their patients or prevent death. Some examples of external stressors might be the death of a patient that the caregiver was emotionally close to, divorce, or loss of occupation.

Vachon (1987) describes some of the physical manifestations of stress within palliative care workers. She

divides these illnesses into minor and major categories. Within the minor illness problems, she found instances of: "constant fatigue, stomach and gastro-intestinal problems, headaches, appetite disturbances involving weight loss and gain, menstrual irregularities, back aches, muscular problems and urinary tract infections" (p. 138). More serious physical illness included: "hypertension, Crohn's disease, cardiac symptoms, migraine headaches, ulcers, anorexia and severe back pain" (p. 139).

Additionally, Vachon found three major themes in the link between caregiver stress and behavioural manifestations. The three most commonly reported behavioural issues were: staff conflict, job-home interactions, and errors in judgement regarding work. Staff conflict and job-home interactions will be discussed later in this chapter.

Benoliel (1988) reported that nurses in palliative settings described continuing exposure to death and dying, interpersonal conflicts and differences of opinion with colleagues, workload and management problems, and the anticipatory feeling of watching patients suffer and die accompanied by having to deal with patients' feelings about their illnesses as the major stressors of working in

palliative medicine. Vachon (1978) found, in her study of how palliative care nurses manage stress, that nurses were attempting to meet not only the medical needs of their patients, they were also attempting to meet the psychosocial needs. The nurses reported becoming increasingly more aware of their inability to perform this function and there was a significant rise in their levels of job stress.

Riordan and Saltzer (1992), in their review of the literature concerning stressors involved with palliative/hospice care, listed nine common internal and external stressors:

1. Inadequate communication between the administrator and staff as well as between staff members.
2. Unrealistic expectations from administrators resulting in staff overload.
3. Conflicts and lack of support from co-workers.
4. Unrealistic expectations from patients.
5. Chronic anticipatory grief and loss.
6. A need to grieve and come to closure consistently.
7. An unrealistic perception and expectation of professional performance by other staff members.

8. Feelings of isolation.
9. Inappropriate motivations for choosing this special field (p. 18).

Additionally, Riordan and Saltzer found that the "one-way giving characteristic of hospice settings can generate negative stress" (p. 21). Each of these stressors affects members of a palliative care team in different ways and is addressed in some form within the present study.

These multiple stressors experienced in palliative care environments underline the importance of caregivers becoming more aware of who they are as people and how they relate to their environment. Vachon (1987) states that because our personal lives mediate our response to stressors found in the workplace, "it is imperative that we understand the effect of [our own personal variables] before we can begin to understand our response to the stressors to which we are exposed as professionals" (p. 11).

One of the stressors not mentioned in Riordan and Saltzer's study or Vachon's work, yet found abundantly in other literature sources, involves working with the families of patients. In the exchange that takes place with each

family member, caregivers may find a menagerie of attitudes, demands and intense emotions that can engulf the best intentions of the palliative care worker (Marquis, 1993). Health professionals must develop the capacity to continuously deal with apprehensive, demanding, angry, and depressed family members (Harper, 1993). Rando (1984) states that often families will project feelings of anger onto caregivers, due to being placed in a helpless situation where they lack control. This anger is often expressed "through non-compliance with medical advice" (p. 334) which can aggravate the stress levels of palliative care workers.

Marquis (1993) discusses these difficult, yet often typical family interactions with palliative staff. He states that family members may behave as if they are the dying member, they will deny the existence of the patient's palliative state, ask innumerable questions of the caregiver, suggest medical treatments and opinions, express doubts of the caregivers' abilities, threaten legal recourse and become jealous of the intense interactions between patient and staff. "Hence, the care provider swims in the midst of bombardment of interrogations, reproaches, or requests for miracles" (p. 28). Plante and Bouchard (1995)

agree and suggest that families, in studies they conducted on nurses working with dying patients, will often "express harmful words to nurses" (p. 94) and question care plans in an effort to express some of the internal rage they are experiencing.

Work stress can also have a deleterious effect on the caregiver's job performance and interpersonal relationships, within the work environment and outside as well. (Clark, 1989). Price and Murphy (1984) judge that "the high stress work done with dying and bereaved persons puts one's intimate relationships at risk" (p. 50). They state that this risk to personal relationships becomes acute when the levels of work stress begin to overtake the coping mechanisms of the care provider and they become burned out.

Stresses also carry over from work to personal lives for palliative care providers as they "feel vulnerable and intensely aware of the preciousness of time" (Foster & Davidson, 1995, p. 294). Worden (1982) concurs with this statement and declares that on a personal level, health care professionals working with the terminally ill bring the continual losses, existential angst and fear around potential losses and death into their home life which

threatens to contaminate and destroy a potential source of stability for the care provider. Vachon (1987) reinforces the belief in the importance of external support stating that "social relationships were seen to be a major source of help in coping with work stress" (p. 35).

Conflict & Role Confusion

Within the hospital system, palliative care teams are found to view themselves and their occupation within the health care system as unique (Vachon, 1987). Accompanying this belief is an understanding amongst palliative care professionals of the "need to develop good team relationships, and open communication" (p. 52). Cooper and Marshall (1978) report that behavioural scientists have suggested "good relationships between members of a work group are a central factor in individual and organizational health" (p. 89). However, this recognition does not necessarily result in effective communication within the care team. Vachon (1988) found that health care professionals working with the terminally ill reported greater levels of stress around having unresolvable difficulties with colleagues and hospital management than

the stress of working with patients and families. "The major occupational stressors were problems with their colleagues as reflected in team communication problems" (Vachon, 1987, p. 12).

Intergroup rivalries amongst professionals working on a palliative/hospice unit were commonly discussed issues in Vachon's (1988) study on caregiver burnout. These oppositional interactions "often led to anger and conflict on the team rather than being dealt with openly and non-aggressively" (p. 153). Rando (1984) states that hospice teams have particular difficulty in addressing anger and conflict, especially when they arise between members of separate professions and disciplines.

Vachon (1988) states that these conflicts often arise due to professional teams or individuals not being appreciated or their roles within the overall hospice team not being understood. Additionally, in Vachon's (1978) study of stress management amongst palliative staff members, she found that: there were often conflicting ideas regarding patient care and treatment; there were unrealistic expectations of support from other health professionals on the unit; and that it was often easier to focus on staff

difficulties than to "accept one's impotence in the face of life-threatening illness" (p. 369).

Marquis (1993) follows Vachon's final point and states that deploying an aggressive stance with one's colleagues provides the palliative caregiver with an outlet for the anger and frustration of the situation of working with dying patients. By focussing this anger on their co-workers, care providers were able to "find a position of passivity, frailty, and sensitivity toward the suffering and the dying of the patients" (p. 31). Vachon (1988) refers to this difficulty as "displaced anger" (p. 156) where the anger around one issue is transferred over to a safer, more acceptable grievance.

Staff conflict was witnessed in such behaviours as scapegoating, separation anxiety, interpersonal or interprofessional rivalry and the aforementioned displaced hostility. These behaviours may often develop either due to unfamiliarity with each other on both a personal and professional level and/or misunderstandings of role definitions within the unit (Vachon, 1987). Plante and Bouchard (1995) found that there was often some degree of ambiguity in the roles of each health care provider,

particularly between doctors and nurses. There was uncertainty as to such issues as speaking with the families, treatment concerns and home care possibilities. Cooper and Payne (1979) concluded that the "mistrust of persons one worked with was positively related to high role ambiguity, which led to inadequate communications between people" (p. 89). This results in feelings of low job satisfaction and a threat to one's personal work identity.

Vachon (1988) describes role ambiguity as "a lack of clear-cut professional role definitions" (p. 151). One of the major strengths of hospice care is the ability of professionals to 'blur' their roles and take on aspects of other jobs. Ultimately this behaviour can strengthen the team but it can also be a major source of stress for those workers who "feel that others are assuming their roles without their gaining other roles in return" (p. 151).

McLean (1979) states that role ambiguity involves individuals possessing insufficient knowledge and uncertainty concerning the responsibilities and expectations, particularly from co-workers, of the job. Workers suffering from role ambiguity / role conflict "have been found to experience low job satisfaction, high job-

related tension, and low self-confidence" (p. 82). Without clearly defined expectations and job guidelines, the possibility for role conflict increases and this will ultimately only serve to exacerbate caregivers' stress levels (Rando, 1984).

Within the hospice environment, Vachon (1988) found that many of the allied health professionals, such as social workers and clergy (pastoral care), believed their roles were being usurped as "nurses are talking about spiritual matters and physicians are doing family counseling" (p. 151). Kahn (1973) describes this form of role conflict as being an impetus for "greater job related tensions, lowered job satisfaction and more intense experiences of conflict" (p. 5). This role stress increases the distrust between team members, reduces respect between co-workers and discipline teams and can severely alter communication, which is essential to the palliative care model. Vachon (1987) believes that the underlying concern behind this stressor is that whatever decisions are made regarding patient care "might prove to be the wrong decision and as a result a patient might die" (p. 53).

Coping

Regardless of the levels and numerous forms of stress and burnout for palliative caregivers, a review of the literature points clearly to taking a proactive approach towards maintaining mental and physical health within the unit (Riordan and Saltzer, 1992). Health care professionals must be supported in the growth process they undertake in order to gain the techniques and personal understanding required in working with terminally ill patients (Harper, 1993). This understanding will then begin to add a new source of strength for the caregiver and provide a higher level of caring to the professional's existing capacity to be helpful.

In order to avoid falling into a period of mental or physical exhaustion, the care provider must be able to recognize that "the impractical expectations one is subjected to are but misplaced emotions (guilt, anxiety, depression) that people try to unload at the providers' expense" (Marquis, 1993, p. 29). Once this recognition is in place, the caregiver will be able to establish authentic contact with the patients and their families. This contact is pure in that the taint of personal loss, trauma and grief

have been addressed and the caregiver will be able to recognize the patients' issues from their own.

Weisman (1987) states that to cope well means, "to reflect, examine, instruct oneself, learn from others, tolerate shortcomings, preserve an optimistic viewpoint, and perform skillfully, though short of perfection" (p. xii). Coping is a learned skill; it is not an innate ability. Within the body of literature on coping mechanisms, there is a paucity of material where counselling as an intervention is discussed. Rando (1984) states that the need for caregiver support is vital, yet in her suggested list of organizational responses she does not include a counselling model. Suggestions from the literature dealing with the general topic of worker stress and more specifically with palliative care professionals include:

- Providing training and education appropriate for the individual's job role with follow up educational opportunities.
- Supporting any transition time for the caregiver moving into a palliative care environment.

- Clearly delineating roles and expectations for all employees.
- Training the staff in stress management techniques to address issues of family, social and work concerns.
- Providing peer support opportunities aimed at enhancing open communication, promoting debriefing and healthy grieving.
- Providing appropriate supervisory support and worker evaluations based on the individual's work performance and psychosocial responses to the work.
- Immediate, specific, behaviourally accurate, non-judgmental feedback to the staff, both positive and negative.
- Promotion of the individual, social, and organizational levels of the appropriate processing of grief. This includes having supervisors meet with caregivers to

address their personal, emotional issues and using team meetings to debrief around stressful situations and deaths on the unit.

- Organizational structures on the unit to provide support for caregivers such as rotating days off, transferring employees to other units and mental health days.
- Dealing with any separation based on discipline lines or job performance questions raised by staff or colleagues.

(Rando, 1984; Vachon, 1998, 1988, 1987, 1978; Cooper and Payne, 1979; McLean, 1979; Harper, 1993; Riordan and Saltzer, 1992; Danbury, 1996).

There is a large emphasis within the body of literature on utilizing a team approach for dealing with caregiver stress and burnout. Vachon (1988) states that "team philosophy, team support, and team building was the most commonly mentioned coping mechanism in hospice caregivers" (p. 157). Riordan and Saltzberg (1992) agree with this finding, and add a personal requirement stating that "existing evidence supports the reduction of internal and

external stressors through a staff-team approach and self-care" (p. 22). Vachon (1988) states that an effective team approach facilitates the grieving process for the multiple deaths and losses faced by the palliative worker by encouraging such activities as death rounds, memorial services or encouraging caregiver attendance at patient funerals.

Harper (1993) sees funeral attendance as a vital coping technique that provides both family and caregiver the opportunity to lend closure to the patient's death. The caregiver is able to say goodbye and the family is given assurance that the care of their family member was not simply seen by the health professionals as a job, but was recognized as an individual. It is also an opportunity to bring cohesion to the team when multiple members of the ward attend these ceremonies.

Rosenfeld and Richman (1987) describe the importance of a cohesive unit in the fight against worker fatigue. When there is damage to relationships or conflict between workers within a team, there is a loss of a potential support network for the individual. "The listening in, the sharing of social reality, emotional support, technical appraisal --

these are all various forms of social support that care providers can mutually provide each other" (Marquis, 1993, p. 31). However, social support is not so easily established and requires a large degree of trust and safety between sharing individuals.

Vachon (1988) believes that in order to access the form of social support necessary to cope with the level of emotional needs a palliative caregiver team, anxieties must be removed and trust established: "Social support is a function of a team which evolves over time and is probably most effective only after the team members are secure in themselves and are able to reach out and trust one another" (p. 158). What is not addressed in any discussions of team cohesion is how to produce team members who are 'secure in themselves'.

Chapter III

Methodology

This chapter will describe the rationale and characteristics of the research method used. Details of data collection and analysis and participants will be outlined and the process of data reporting and the task of the researcher will also be discussed.

Researcher Role

Since my role as a researcher comes to bear on this study, it may be helpful to offer a summarized statement of my personal and professional background. I am a graduate student in Counselling Psychology with past experience in Child and Youth Care Counselling, working with behaviourally challenged children in elementary school settings. I have also volunteered with the Richmond Hospice Association and completed the Hospice Training Program that they offer. This volunteer experience, coupled with the death of my grandfather in 1992 in a palliative care ward in New Westminster, and the recent death of my uncle in a palliative care ward in Victoria reduces my objectivity to such a study. In addition, there may have been a concern

around the involvement of hospital management with the study as they are stakeholders in the project. It was important that, as the researcher, I separated myself from contact with management after the initial discussions about the project took place. In addition, I addressed any concerns around management connections with participants in the opening minutes of the interview sessions.

My own expectation biases lay primarily in my own belief in the counselling model as an effective intervention technique for coping with stress, burnout, and staff cohesion, etc. I have done my own work as a therapist with clients who had many similar issues to those reported by the health care professionals working on the palliative unit and I have witnessed significant changes within these clients.

I have attempted to bypass these biases by diligently reporting, in detail, all examples of participants' experiences. In addition, I made a conscious effort to vary my tone and posture within the interview session so that verbal and non-verbal reinforcement of particular topics or themes did not occur. Self-monitoring and continual reflection with my research supervisor has, I believe, limited any negative effects of my personal biases.

Methodology Description

In the present study, a qualitative, modified phenomenologically based approach was taken in addressing the impact of a counselling consultant position, designed to be used by health care professionals who are members of the Palliative Care Ward at St. Paul's Hospital in Vancouver. The central theme of questioning was: "What has it meant to the health care professionals to have taken part in individual counselling?" This was addressed through a semi-structured interview that allowed for tangential open-ended questioning of the individual's experience. The role of the researcher was to elicit through interview sessions the structure and themes of the participants' experiences at or near the end of their sessions with the counselling consultant.

Phenomenologically based research places an emphasis on the "individual's subjective experience" (Tesch, 1990). It seeks the individual's perceptions and the meaning of the individual's experience. These perceptions provide the basis for understanding events from the participant's point of view. Mertens (1998) emphasizes the key characteristic of phenomenology as "the study of the way in which members of a

group or community themselves interpret the world and life around them" (p. 169). The researcher does not make assumptions about an "objective reality" that lives outside the world of the participant. Instead, Mertens states that, "the focus is on understanding how individuals create and understand their own life spaces" (p. 169).

This structure is based on a type of "grounded theory" (Glaser & Strauss, 1967) where the researcher bases hypotheses on the descriptions of the participants rather than on assumptions derived from an exploration of literature. For example, instead of seeking out specific changes in levels of depression amongst Palliative Care health care professionals due to a counselling intervention, this study sought to discover how the participants found personal and professional meaning in their involvement with the counsellor. The patterns elicited from the participants both individually and as a whole reveal the impact of the intervention from the participants' own perspective.

A qualitative, modified phenomenologically based methodology was employed due to the fact that the most crucial information on the effectiveness of the counselling intervention would lie within the descriptions put forward

by the participants of the study. A more quantitative approach to this study would risk missing the social and value-laden quality of the interview process. Through open-ended questioning in the interview sessions, the participants were able to reveal their insights and perspectives in a holistic and more integrated fashion. This allowed the interviewer to more accurately elucidate the intervention's effects on the participants during the analysis of the data.

The decision not to include quantitative measures such as the Beck Depression Scale, Speilberger's State-Trait Anxiety test and other stress and coping measures rested on several factors: 1) the available population of health care professionals who had participated in the counselling intervention and who agreed to be interviewed was small; 2) the population receiving the counselling intervention was not selected at random nor were the participants who agreed to be interviewed, due to logistics; 3) no measures were introduced prior to the introduction of the counselling intervention and therefore a pre/post test structure could not be employed; and 4) limited access to the health care professionals on the Palliative Care Unit negated the

possibility of a control group. This study allows that in the future there is potential for effectively employing both quantitative and qualitative measures when a larger population is made available.

As qualitative methodologies are primarily concerned with questioning participants as to how they view their world and understanding actions and meanings in a subjective context (Silverman, 1993), the participants and the researcher become engaged in a cooperative, co-researcher relationship. Through the interview process, the researcher builds rapport and trust with participants in order to encourage a more thorough description of the experiences and perspectives and personal information. The researcher's approach to the interviews was therefore light and often humorous with the goal of making the participants at ease and providing a venue that would allow for a more comfortable, less interrogatory experience.

According to Glaser & Strauss (1968) the usefulness of qualitative research, such as the phenomenologically based approach in this study, is challenged by the precision of the data. Since qualitative data does not lend itself to simple summarization, it is essential to provide sufficient

detail to enhance credibility. The use of the interview / transcription method, according to Kirk and Miller (1986), is satisfactory in ensuring reliability of the descriptions of study participants. Silverman (1993) states that ensuring qualitative validity is a matter of the researcher refraining from making "spurious correlations" and instead seeking to reflect only that information which lies within the data. The phenomenologically based approach encourages this by asking the researcher to serve as a reporter of sorts without straying into the realm of extrapolator.

Glaser & Strauss continue the link between validity and reliability to credibility. Credibility is equated with the trustworthiness of the researcher. Validity and reliability, they argue, are analogous to trustworthiness in a qualitative study. The present study addresses the issue of trustworthiness through:

- Explanation of data collection procedures. Descriptions of initial contact with participants, study introduction letters and interview questions are appended to reinforce co-researcher perspective.

- Transcriptual data is provided for potential re-analysis. Researcher questions are abbreviated for logistical reasons.
- Negative instances are reported within the data set.
- Interviewer and participant bias is acknowledged and addressed.
- Interpretations of data and the data set are separated to reduce the risk of improper correlations and assumptions.

Participants

Participants were not selected on the basis of demographics. Due to logistical concerns, participants were taken on the basis of personal availability. The counselling consultant intervention took place in St. Paul's Hospital in Vancouver, BC between June, 1998 and January, 1999.

Participants in the intervention were health care professionals who were employed by St. Paul's Hospital and assigned to work on the Palliative Care Ward. The

intervention was requested by these employees and was granted funding after the suicide of one of the nursing staff in 1997.

Initially, participants were introduced to the counselling consultant who participated in team meetings in May of 1998 as a way to familiarize health care professionals with who she was. This was followed by a period of self-referral that continued throughout the course of the intervention. At the time of this investigation, approximately twenty-five workers had been actively involved with the counselling consultant. The first eight participants who contacted the researcher were selected for the study and interviews were scheduled.

These health care professionals ranged in age from late thirties to late fifties and represented a variety of professions on the unit. Six were from the nursing team and two were from the allied worker team that includes occupational therapy, pastoral care, social work, and music therapy. There were no physicians in the interview set. Although the hope of this study was to have equal gender representation, all of the participants in the study were female. No male participants in the intervention self-

referred themselves to the researcher.

Recruitment

After receiving ethical approval from both the University of British Columbia and St. Paul's Hospital, the counselling consultant distributed the name and phone number of the researcher to the participants in the counselling intervention. Participants then self-referred themselves to be interviewed with the understanding that refusing to participate in the research would have no negative implications for either their job situation or the availability of the counselling intervention. Those individuals who agreed to be interviewed then made appointments to meet with the researcher in the hospital environment but away from the Palliative Care Ward. As this is an exploratory study, only the first eight individuals who volunteered themselves to the research were chosen to be interviewed. Sixteen individuals contacted the researcher but were not able to be used for this study. Consent forms were signed and the interview process was explained at the beginning of each interview. Some rescheduling had to take place due to a strike within the Health Care System and all participants were able to be interviewed.

Data Collection

Participants were interviewed in an office within St. Paul's during either their lunch breaks or time away from work. Each individual was interviewed individually in order to maintain a focus on the individual's experiences and perspectives of the counselling intervention. Sessions were booked with buffer zones of one-half hour to prevent participants from seeing who was being interviewed and thereby maintain confidentiality.

Interviews were recorded on audiotape in order to ensure free flowing dialogue and to maintain a conversational style of discussion. Concerns that individuals had around the taping of the interview sessions were addressed before the tape machines were turned on. All participants were aware that the tapes would be destroyed once the sessions had been transcribed. One participant brought forward these concerns. The other seven individuals stated a high degree of comfort with being recorded and described feeling pleased to be able to relate their experiences.

Questions were asked in an open-ended form that included an opportunity to explore both positive and

negative events that occurred within the overall experience. Participants were provided the opportunity to offer suggestions for improving the program by providing areas of personal concern and dissatisfaction with the counselling process. In this way, both positive and negative experiences of the intervention were taken into consideration.

Participants were informed that all reference to names or unique individual occurrences would be omitted to maintain anonymity within the research study. Interviewed subjects were informed that the study was to be reflective of their opinions of what the counselling intervention had meant to them personally and that it was not intended to critique or evaluate the technique in general.

The researcher transcribed the data and reviewed it for themes and categories. To ensure minimal or no bias in the process of eliciting themes from the transcripts, the research supervisor reviewed the extrapolated themes to ensure greater reliability in the results.

Rationale for Interview Questions

The interviews followed a semi-structured format where general questions had been prepared in advance. These

questions were designed to elicit the personal experiences of the participants and it was expected that further questioning would arise from each of the nine structured questions. The use of standardized, general questions was based on the belief that flexible, unstructured interviews may offer a more intensive study of feelings and perceptions of the individual but lack comparability of one interview with another (Sellitz et al, 1964). Additionally, there is a greater burden on time and difficulty when addressing unstructured interview sessions. (Silverman, 1993).

Questions ranged from the number of sessions that they had participated in to how they believe the counselling intervention has impacted their professional environment and interaction with colleagues. The final question involved soliciting a summarizing statement about the participant's experience and / or belief around the effectiveness of the counselling intervention. Many of the answers required further elaboration and probing which was provided in the form of an open-ended question. Interviews ranged in time between one and one and one-half hours.

Interview Questions

- How many sessions have you attended with the counselling consultant?
- What expectations of counselling did you have going in?
- Were your expectations of counselling met? If yes, how were they met? And, if no, why do you think they weren't met?
- For background information, could you please describe for me the most stressful elements of working on the Palliative Care Unit?
- What enabled or made it possible for you to attend counselling sessions? Was there anything that hindered you or made it more difficult for you to attend?
- What was the main issue that brought you into counselling?
- Could you talk about if there were any changes you were aware of with your personal life or your home environment/interaction with friends and family?
- Have you been aware of any changes in your work environment or your interactions with colleagues since you began your counselling sessions?
- Are you aware of any changes in terms of your level of job satisfaction or any changes to your job performance since you began counselling sessions?

- At the end of interviews, I like to ask if there is one or two things that you want to make sure that I heard you say or that you believe really needs to be heard in this study, what would that be?

The interview questions were devised based on two main sources: the initial stages of discovering research literature and discussions held between the researcher and professional individuals who had done group work with the health care professionals on the Palliative Care Ward and a physician who works on the ward and procured funding for the project. This physician did not participate in the intervention. This information, particularly the feedback provided by the professional individuals who had previously been connected with the Palliative Unit, led to the present questioning format and provided a structure that allowed for a full and complete description of the participants' experiences.

Data Analysis

Audiotapes of interviews were transcribed with researcher responses abbreviated to provide a greater focus on the information provided by the interviewed individual (see Appendix). Transcriptions of interviews were read and re-read to enable the researcher to become familiar with the

themes and patterns within the individual record and the larger record of the whole study.

Categories were formed from the standardized questions and themes were elicited within each category based on repetition within the larger record. Statements that appeared in two or more individual transcripts were considered as being themes and were included in the data set. Each theme was reinforced with two to four examples from the larger record.

One possible weakness of the data analysis may lie in the fact that participants were not able to review their individual transcriptions due to logistical difficulties. For this reason all references to individual responses that would be identifiable and would threaten anonymity were removed from the data set. These responses remain within the larger record to preserve accuracy with the hope that the opportunity for individuals to review their data may occur in the future. Only one response was withheld from the study and therefore the researcher does not believe that this occurrence poses any challenge to the validity of the results of this research.

Chapter IV

Data Analysis

The data has been organized into categories based on the semi-structured interview questions used in the interview process. Each category is presented accompanied by the question asked in the interview sessions. Themes follow the questions along with three to four transcribed responses from the study participants relating to each theme.

Thematic Data

Category One: Expectations of Counselling

Interviewer Question: What expectations of counselling did you have going in?

Theme One:

The majority of participants believed that counselling would aid them in increasing their self-awareness around how they interacted with their colleagues on the Palliative Care Unit. This awareness particularly included getting feedback from the counsellor on specific incidents they reported to her and processing how they could have been handled in a

different manner.

Examples:

"I guess just an increase in my self-awareness and how I operate on the unit . . . interacting with other people because, you know, I have trouble interacting with certain people and, you know, part of that is that lack of self-awareness and increasing that . . ."

"My expectation was basically to have an immediate opportunity to have discussions with someone who has a really . . . who understands the big picture on the unit and on a few occasions to get feedback on particular incidents."

"Oh . . . insights into behaviour. Others and myself and how to deal with it on an empathetic level without getting pulled into the emotion of it."

Theme Two:

Many of the participants reported that they expected to have a professional person, someone who was impartial and not attached to the hospital, to talk to who understands the dynamics of the Palliative Care Unit.

Examples:

"To have someone that was not attached to our hospital or our unit, unbiased and out of the scenario that would listen, number one, who would listen and number two, help

deal with whatever things I felt I needed to have help dealing with."

"You need someone totally objective, outside of the whole thing. To me, that's what counselling really is. I don't think it would be comfortable if they were from the unit. It wouldn't be as confidential. I feel that with the counsellor we have right now for this project. I feel trusting. I trust her and the confidentiality."

"It's nice to talk to somebody, at least as time goes on, who will have more understanding of the dynamics of the workplace. I mean, you can go to other counselling and it's a bit more hypothetical and the counsellor is drawing just from . . . more from principles. Even though [counsellor's name] wouldn't be able to divulge what someone else had said but she would know about a particular incident and it just gives another dimension to your discussions about the workplace."

Theme Three:

A number of the participants also went in to see the counsellor around personal issues away from the workplace. They were seeking to increase their understanding of family dynamics, interpersonal interactions, etc. and to address stressful situations instead of relying on non-professionals (friends, family, co-workers) for this type of support.

Examples:

"Well, I didn't really know what to expect but there were a few things about my own life that were bothering me . . . I just thought that if there was someone that, other than unloading on friends or something, someone that would help maybe process things that was a professional person then maybe that would help me."

"I was hoping that I could get my own shit together. You know, if I could talk to somebody and I mean, I have certain people, like good friends and colleagues who I talk to and they all share pretty much the same frustration of work and, you know, how difficult it is. . . but I felt if we had a professional person that was the kind of person I could talk to who would be able to help me see what I needed to do."

"Guidance. Support. Inspirations. Different ways of thinking about troubling things . . . [counsellor's name] and I haven't talked a lot about palliative care. We've talked a lot about my own situation and that in turn helps me function better on the floor."

Category Two: Were the expectations of counselling met?
If yes, how? If no, why not?

Interviewer Question: Were your expectations of counselling met? If yes, how were they met? And, if no, why do you think they weren't met?

Theme One:

The majority of interviewed subjects reported that their expectations of counselling were met by the therapist. They were able to be met by the counsellor listening to their perspective and then giving them feedback that helped expand that perspective. This feedback was specific in that it included the viewpoints of other health care workers from the Palliative Care Unit that allowed the client some insight into how others perceived them in particular situations.

Examples:

"Yes. Definitely, because, you know, we talked about one particular patient and you know, she heard about this patient from other people and it was a very difficult case so she sort of got a global aspect about this patient and so, you know, I talked to her about what it was like looking after this patient and some of the difficulties I felt working with the team."

"[Counsellor's name] has heard my perspective on others but I know she has heard other people's perspectives on me. She had brought up that in terms of a generalization around a particular patient and she brought up certain trends that people, people's resentments and that kind of thing."

"Well, crises develop and sometimes they pop right away but there's a lot of dynamics and feelings around that and to know that a counsellor has awareness of that is just more helpful to put things in perspective."

Theme Two:

Interview subjects also reported that the counsellor met their expectations by providing a place where they could talk openly about topics and then get feedback, suggestions or options that helped them address their issues from different perspectives. This feedback did not include specific reference to incidents occurring on the ward.

Examples:

"I can remember talking to [counsellor's name] and saying how difficult it was to work with this particular patient and just having someone to listen without being personally involved. Just to hear how difficult that was. Just to have someone there to listen and hear that was helpful."

"Well, by listening and when, depending on what was needed,

either providing feedback or giving a suggestion, saying 'what about this?' and you know, an option."

"How did she? Well, I suppose I felt very supported and she gives an awful lot of food for thought . . . I don't think I'd use the word suggestions as such but maybe food for thought says it better. There have been suggestions like books to read, that type of thing, yes."

Theme Three:

There was an element of concern for a couple of the interviewed subjects with regard to the confidentiality of the counsellor due to the multiple perspectives she would provide in giving feedback to clients. Participants questioned how the counsellor could remain objective when they were dealing with so many people who had such differing perspectives on the same issue.

Examples:

"Towards the end I was wondering how she could be objective. How could she remain objective when she's seeing all the people from the same place? You know, when you go to see a counsellor off site, your counsellor is with you usually and can guide you but how can she remain objective when she's got all the same people from the same unit giving her aspects of the story."

Question: "So, [counsellor's name] is able to reflect back

to you other sides of particular issues on the ward in an anonymous way?" Answer: "Yes, but that was a concern of mine though because, I did bring this up to her, because of the confidentiality factor and the objectivity too."

Category Three: Stressful elements of working on the
Palliative Care Unit

Interviewer Question: For background information, could you please describe for me the most stressful elements of working on the Palliative Care Unit?

Theme One:

Many of the interviewed subjects felt that one of the most stressful elements of working on the Palliative Care Ward was having their professional opinion or perspective on a patient heard by other health care professionals. They felt that many of their colleagues had their own agendas and did not work cohesively as a team.

Examples:

"Working in a team with so many different personalities. Devising effective ways of being heard. Heard within the team. I guess looking after patients whose goals aren't always met because of the ineffectiveness of the team [is one of the stressful areas]."

"The frustrations I was feeling from other staff, from other members of the team . . . That was where my frustration was, that they had their own agenda and that was not mine."

"Well, one is working with the staff because we're all strong . . . We're all strong, assertive, firm in our ideas

people. So, working with some staff and I'm sure it works both ways that just sort of bombard, my way or the highway and no negotiation or no 'let's talk about it and see what we can do'."

"It's absolute magic when the team is working together and we're united but when that team is fragmented and going off on different tangents, that's the major frustration is everybody has their own agenda. 'My way is the only way'."

Theme Two:

The majority of the interviewed subjects reported that one of the greatest stresses that comes with working on the Palliative Care Ward is dealing with the loss of patients and sharing a space with them as they die. They reported issues arising for them around their own mortality and reliving losses they have experienced in their past.

Examples:

"Sometimes it has been stressful having . . . people that are my kids age or younger than my kids. We've had a lot of that and we have a lot of people that are the age of my kids around 34 to 38." Question: "How is that stressful for you to have people in their thirties?" Answer: "The one person I can think of who was, actually he was the age that my son would have been if he had been alive, he was the first person I could admit to myself that, 'Oh my God. It's going to be hard looking after this man.'"

"The constant dying process which is always different . . . The ongoing losses, which were ongoing. I didn't have the resources within myself to deal with the ongoing losses. I needed to be in a place where everybody wasn't dying."

"I can say right now that there are times when certain patients I really connect with on a different level, and then it's hard when they die and someone died just recently where that's the case for me."

"On Palliative Care, you're talking about life, you're talking about death and you're being faced with your own mortality and it's like how is that affecting you from day to day and having sort of a conscious awareness of that."

Theme Three:

Another largely reported stress by the interview subjects was around the stress involved in being judged by colleagues and hearing personal attacks, having people talk behind your back and having to work in a tense environment where the atmosphere is not friendly or cordial.

Examples:

"[There is] a lot of angst. Well, talking behind people's backs mostly. And it can be very fleeting and quick while you're doing your work or it can be sit down and gossip but that kind of thing I find is very undermining."

"Oh, there's . . . I mean, people have judgements of me so

I've got judgements of others. Worrying about how somebody's going to show up for the days work and how to handle them . . . and inappropriate behaviour of some staff with their colleagues."

" . . . they've trashed the social worker, they've trashed the pastoral care woman, every pastoral care person."

Question: "When you say 'trashed', what are you seeing specifically?" Answer: "Very critical of their work. Very critical of her."

"Sometimes I feel that there is more judgement than self-reflection in terms of their own stuff and their own capabilities. You know, there's not much positive reinforcement . . . 'oh, you did a good job'. That kind of thing. It's always a negative that comes out."

Theme Four:

Some of the interviewed participants reported that having disagreements and a lack of cohesion between the professional groups (nursing, doctoring, and allied workers) has been a stress for them. This ranged from having disputes over job descriptions and duties to feeling excluded from the socialization and support of another professional group.

Examples:

"I think sometimes there's a lack of understanding from other disciplines that they feel you're taking over their job. Which is not the case. It's hard to explain to them

that this is part of our job too."

" . . .there was another time when someone who I had a strong connection with died....that's one place where my perception on being not a nurse and that it's that they support each other you know, with a word or a hug or something, but someone like me is not included in that."

"I think that over time the nurses have learned some of the basic stuff that I do and I know that [one of the allied health care providers] was on the unit recently and she felt that there's not even a role for her because the nurses do it all."

"But, people I think sometimes have still got their roles defined as what they can only do this and they can only do that. It's still the nurses answering the bells all the time while the [allied health care workers and doctors], they don't answer it."

Theme Five:

A number of the participants stated that the lack of support from colleagues and the lack of leadership are stresses for them. This, accompanied by the conflict between the personnel on the Palliative Care Ward, was a great concern to all of the subjects interviewed.

Examples:

"Now, if there was conflict, which there always is, well you

would have to work that out. Well, who is going to confront someone when you've got all these other things going on in your work and to go and say to somebody, 'What you did has really hurt me' and not having any support or any backup. No. No. That was very poor."

"Not too long ago we had a team meeting and it was such unpleasantness with this particular patient and I was in the room with this person when she was yelling at her husband and what she was saying . . . but I was being told by this other team member, 'No, you can't say that'. What do you do? That's really painful. That's certainly not supportive."

"I mean, I saw a lot of major conflicts on the floor where people were actually yelling at each other. I saw one male nurse actually leave the unit in the middle of a shift and not come back because he had a fight with one of the girls."

"Another thing, you know, with those conflicts up there and stuff. You were always expected to take sides and there were camps. There were people that, you know, got along with one another and you would get caught in the middle."

Theme Six:

An additional stress for the participants was working with the families of the dying patients. Often, even when it was not effective, patient's families would request procedures that were intended to prolong the patient's life. Many of the interviewed staff felt this was very challenging to deal with the desire of the family to keep the loved one alive when that was not going to happen.

Examples:

" . . .like last night I had a woman who's being tube-fed and she just looked terrible and so I wanted to say to her family, 'You don't have to do this. She doesn't have to have these feedings. You know, you can start thinking about stopping this because she isn't leaving the hospital bed'. But it's sometimes difficult to bring these things up with people."

"Pain medication we can play with but when to stop giving patients medications and other medications and tube-feeds and stuff like that. When to stop all of that, all the interventions."

"Another stressful thing that will probably always be because if it wasn't always you wouldn't be able to grow as a unit, as a person and as a team, is when people want more treatment. I think that the treatment is more towards a cure and we're doing them more harm and hurting them rather than palliation and comfort and quality. Tube-feeds, blood transfusions and going down for a CAT scan. The person might be dying in an hour but the family might be pushing for that."

"Yeah, it's hard. Sometimes they're bleeding, they're on their last two or three hours of life or maybe a day or two and it's stressful not to be able to get a family to see that or sometimes it's the patients too. But then you can't take people's hope not matter how little it is."

Category Four: What enabled the participant to attend counselling sessions? What hindered them?

Interviewer Question: What enabled or made it possible for you to attend counselling sessions? Was there anything that hindered you or made it more difficult for you to attend?

Theme One:

The majority of the interviewed participants reported that having the counselling office located within the hospital helped enable them to attend counselling sessions. This meant that they did not have to spend extra time commuting to an off-site location and that they could go before or after their work hours.

Examples:

"Well, I usually go after I finish because I finish at three so I can go right over after I finish work . . . Well, I live in [suburb of Vancouver] so, I mean certainly it's convenient after work."

"Oh, it's great. Absolutely. It's wonderful being able to access that kind of an appointment and not have to make extra time to somewhere. Again, because I'm doing it in my work day or attached to my work day, that's what's been great for me."

"That was helpful for me. Yes. Because I wouldn't have gone as often or maybe at all if I had to go outside the hospital and it was a taxi ride or a bus ride or whatever."

Theme Two:

Some of the participants reported that they were hindered to a degree by having the counselling conducted in a part of the hospital where co-workers had the opportunity to see them waiting. Additionally, there was some difficulty when the office was moved and a client was not informed so she had to phone the Palliative Care Ward to find out the new location.

Examples:

"But the only difficulty I found was the actual physical thing where . . . I was sort of out in the hallway and there were people, you really didn't want to be seen that much you know because you still sort of have these things about well, she's having problems or something. There wasn't enough privacy surrounding the actual appointments and stuff sometimes. I think an off-site would have been a whole lot better actually."

" . . .when I came back from being away, [the counsellor's] location had changed. So, I went for my first appointment to the wrong place and of course no one around there really knew because she was really someone who parachuted in and

out again. So, to make a long story short, I ended up phoning up to someone I knew on the unit who I knew would know where she was."

"What was an issue for me when it was in the social work department was I needed to be respectful of, like there was a couple of times that I went to the social work department and somebody would be waiting in the waiting room to see [the counsellor] or I could overhear a voice."

Theme Three:

Another member of the participating health care workers stated that one of the reasons she attended counselling was because it was a free service.

Examples:

"And actually the cost factor too. I don't think I could have afforded to go if I'm being truthful, but I'd be willing to pay, you know, if the rates were changed, if [the counsellor] could get some funding from the hospital, I'd be willing to follow through with that."

Category Five: The Main Issue that brought the
participant to counselling

Interviewer Question: What was the main issue that brought you into counselling?

Theme One:

A large number of the participants said that the issue that they wanted to address coming into counselling was around working with particular patients who caused them to face their own fears of death and to deal with more global issues of sadness and loss.

Examples:

"Well, with this patient, you know I've never journeyed as far with anybody else in terms of, because she was absolutely terrified of dying and you know she's only a few years older than me so, it's just in terms of tapping into my own mortality. I'm looking at myself and dying young and that kind of thing . . ."

"Well, I saw looking after this patient as a gift in terms of learning more about myself, learning more about my personal boundaries and just getting a deeper essence of the fragility of life."

"Well, it was the death of a patient, a young woman who I was quite involved with. She died a month ago . . . So, I've heard of things that, people's judgement on me with this

patient but they haven't talked to me about it."

"I was having a lot of pain in the summer. I connected very closely with a patient and it was very painful for me for a whole lot of reasons and I've talked to [the counsellor] about that and I'll be honest, I haven't really in the last weeks even thought about this patient but just talking about her now I feel myself getting emotional that I haven't felt for a long time."

Theme Two:

An equal number of the interviewed participants reported that the main issue that brought them to counselling was around relationships with family members, friends and acquaintances that were causing them difficulties. Some of these participants spoke about how they understood there was a link between home life and work life and they expressed a desire to heal their home life initially and that would affect their feelings around work.

Examples:

"The main issue was myself and my family situation and although I'm well aware that my situation impacts my work and vice-versa, I've approached it from the point of view that when I'm totally comfortable with what's happening to me then I'd be able to talk about other things.

"Through the course of my time with [the counsellor], my daughter experienced [a loss] which had a big emotional impact on us all and [the counsellor] was really helpful. I even have tears come up as I talk about it now."

"One was just something that was bothering me about a relationship. I had just gone through this experience, like I dumped this guy and I wasn't sure if I should have or not. I was beginning to question you know, is there something wrong with me."

Theme Three:

Other interviewed participants spoke about feeling concerned about their interactions with some of their colleagues on the Palliative Care unit and they were seeking ways of improving their communications and relationships with others.

Examples:

"Interactions on the unit. Well, it's really incident related you know, and there have been a few fairly significant incidents that have occurred in the last three months. So, it's just helpful to talk with her about that."

"It was around the whole fact that I strongly felt the team was falling apart . . . Well, there was a lot of bickering and a lot of, there was tension when you came in in the morning. There was tension and you wouldn't necessarily speak to somebody or even make a comment in general because someone, as sure as God made little green apples, would

snarl at you."

Category Six: What changed for the participant in terms of their personal issues and/or home environment?

Interviewer Question: Could you talk about if there were any changes you were aware of with your personal life or your home environment/interaction with friends and family?

Theme One:

A number of participants reported increased feelings of self-awareness around their personal issues and boundaries. They described part of the change as being able to separate their personal problems or concerns from their work-related problems or concerns.

Examples:

"Well, I guess just that increased self-awareness and I guess getting in touch with my own woundedness and how it's brought, how that woundedness gets brought up in my interactions with patients and that kind of thing."

"I guess, getting back to more of an awareness of myself and my own stuff and what the patients stuff is. You know, it's that fine line of getting too involved and not getting involved as such."

"I had a very bad experience with a patient who just was making me crazy. Oh my God. He just would . . . he was the kind of person who just pushed every button I had. It was

just my father all over again. The way he spoke to his wife, the way he spoke to his family, how he had no consideration for anyone else . . . That's why I felt the way I felt because this was my background. This was the way my family was. My father's word was law and there was no discussion . . . How else could I not react? I mean, it was perfectly sensible. But, it was taking that time to talk about and understand well, that's why. It's not rocket science. It made perfect sense. And once I realized that, I was able to be therapeutic in how my interaction with him was."

Theme Two:

The majority of patients reported that they were beginning to look after their personal health and emotional well being more than they were before counselling. They described feeling physically healthier and not as fatigued as they were previous to counselling.

Examples:

"I'm feeling good. I'm feeling good. I'm looking after myself. I'm finding the days are . . . I have to get up at ten to five to have quiet time in the morning. I think for myself I'm feeling more at peace with myself. I guess I'm healthier."

"And these sessions with [the counsellor] have given me the opportunity to explore what it is that I want to do with the rest of my life and that sort of thing. Realizing that you don't have a whole lot of time left. So, that's given me extra food for thought. That's personal stuff."

"Well, I'm not having much interaction with my dad because he doesn't think I care anyways so I've let him go . . . I don't feel a need to talk to him to justify who I am but before I thought I had to justify who I was and that I did care."

"I'm actually taking better care of myself physically and emotionally I think so I don't need to avoid the unit. I don't need as many mental health days."

Theme Three:

Interviewed participants also described leaving the issues and problems they experienced at work behind when they were going home. They admitted to having some discussions but that they didn't need to unload their work-related issues in their home environment.

Examples:

"I don't take my work home anymore. Actually, if I do take it home, my husband is there and my daughter and they don't really understand but they'll listen a bit and they'll nod their head but at least I can say things to them and then it's gone."

"I don't take a lot of the sadness home with me where I used to before."

"I'm not quite so crabby at home."

"Well, I suppose if I'm not as feeling the tension, I'm able to be more relaxed and not as worked up about things. That does have an impact on everybody. Question: So, is that the tension from work that you're taking home? Answer: Well, just the tension that I carry. That's lessened. And I'm able to be a little more objective about things at home. You know, less reactive."

Theme Four:

Interviewed Participants also described feeling stronger bonds with family members due to their recognition of their own issues. They discussed being more immediate with their family and friends when addressing issues that concerned them as well.

Examples:

"Well, I think it's improved my relationships. I'm being a lot more upfront and sort of realizing more what's right for me. Just in terms of speaking up more instead of just letting things you know, ride as such."

"My husband, I'm not reacting to his behaviour which is quite obsessive compulsive and I'm letting him be him. Because he's quite laughable sometimes and we have a joke

about it. I let him be with it. I don't have as many reactions to him. About ninety percent less. So, [the counsellor] has helped me with that too."

"It's changed for the better. It's very hard to try to put into words isn't it? Something that's terribly hurtful but I suppose it takes a great deal of time, a transition of this sort does and as a lot of transitions do and you're constantly framing things as you go. Framing things for yourself, re-framing things for your children and so [the counsellor] has been able to kind of help me more along that continuum of taking me from where I was when I started."

Category Seven: What changed for the participant in terms of their work environment and interactions with colleagues?

Interviewer Question: Have you been aware of any changes in your work environment or your interactions with colleagues since you began your counselling sessions?

Theme One:

A majority of the participants reported an increased awareness of themselves and their colleagues on the Palliative Care Ward addressing issues / problems immediately instead of avoiding engaging these issues. Additionally, some participants reported that this immediacy included becoming aware of when to engage in a situation in the work environment and when to step back from it.

Examples:

"When this particular patient died, a nurse colleague told me that two people felt they couldn't go in to say goodbye to this person because I was in the room and so I had to go up to those two people and approach them . . . I didn't let it lie." Question: "How would that situation have been different from before seeing [the counsellor]?" Answer: "I probably wouldn't have said anything."

"Actually, something that I happened to be in the nursing station just now and it was just a bit of a . . . it could

have been a potential conflict over who got asked to do a particular shift and the clerk who did the organizing didn't ask the more senior person and it was resolved amicably right then."

"Well, if I have an issue with somebody and they say, 'Oh, you were a bit abrupt' or something like that I can, I say, 'Well, can we go talk about it' or something like that. So, there's not a judgement there. Most of the people I can talk with now."

"Everybody is, like I think the whole team, all disciplines are trying to, if they have something that's bothering them they'll deal with it right now or if it can't be dealt with right now with the person they'll make a date or a time when it can be dealt with."

Theme Two:

A large number of the interviewed participants stated that they are feeling as though there is less negative energy and tension in the workplace. They believe that others are hearing them more and they are also making more of an effort to listen to their colleagues.

Examples:

"Yeah, or even the energy. The negative energy. Less negative energy. It's hard to work in a negative environment."

"If I'm having issues I think I talk differently to doctors and hear their point of view as opposed to making a judgement of why they're making the patients have a tube-feed or something. They may know something about the patient that I don't know. So, I'm more open to listen to their point of view."

"Well, there's less tension. . Well, you can go in in the morning and . . . we can just talk and they've made the coffee and you can shut the tape off and say something in report and nobody's going to jump down your throat. It's easier going and people are more, they can say right away. I think we used to carry a load of grudges and I don't think people are . . . we're working hard at not doing that."

Theme Three:

Most of the interviewed participants also described a work environment that involves people being friendlier, that there is less arguing and conflicting between staff members, and that the level of gossiping and discussion of colleagues when they are not present has significantly been reduced.

Examples:

"Before what I used to do is I'd come and I'd say, 'It's okay. You're just going to do your job. You do what you have to do and be as friendly as you can but basically mind your own business. Now I feel that I don't have to. I'm a little bit freer in being myself because . . . there isn't as much conflict around these days."

"Other than the last week or two, previously it felt very good in terms of communication and co-operation amongst staff." Question: "Is that a change from before?" Answer: "Yes."

"Well, I felt more that the nursing staff were more aware of my role or were more willing to listen. There was just more acknowledgement of presence, you know, saying 'hello'."

"Something I feel is that we're more caring of one another now and the way that we talk to one another except for a few who are having off days. And I can verbalize how I'm feeling without getting judged I think as much. You get more compassion and empathy than gossip."

Category Eight: What changed for the participant in terms of job satisfaction and job performance?

Interviewer Question: Are you aware of any changes in terms of your level of job satisfaction or any changes to your job performance since you began counselling sessions?

Theme One:

A few of the interviewed participants reported that during the period of being involved with the counsellor they hadn't seen any changes they were aware of in their job performance.

Examples:

"I don't think it has. I don't think it's changed."

"I couldn't honestly see if there's been a difference in my performance."

Theme Two:

Some of the interviewed participants reported that they were happier within themselves and they weren't feeling as depressed. They stated that this feeling had resulted in a

feeling of looking forward to coming to work instead of dreading working.

Examples:

"I don't know. I feel happier within myself. I don't feel so dragged down. It's bringing up so much stuff for my own self. I don't know. It's an odd feeling."

"I feel actually, I feel really good these days and I feel really good about being at work too."

"Patient care has improved because I think we're all less tense. We're basically happier and those that aren't happier have gone on to other things."

Theme Three:

The majority of those clients who were interviewed stated that the decrease in conflict between colleagues has allowed them to relax at work and refocus their energy to patient care. They reported feeling more present and less distracted by issues on the Palliative Care Ward and they feel they are able to complete their work more effectively.

Examples:

"I guess because there isn't as much conflict around these days as there was so you can actually relax more and say, 'Okay. We can actually get through these eight hours. You know who your patients are and what you have to do'. You just do it."

"I'm more present and less pulled into other people's stuff so I'm working more effectively. I'm getting on with my job as opposed to getting pulled into other emotions and there's less emotion around the ward, around the nurses."

"I've always liked my work. I haven't liked getting there but once I get away from the other people and get into the work, I've always liked it. But now, it's ok to get there and talk to the staff and have our 'good mornings'."

"Maybe the performance is different because there's less tension and everybody....well, it's nicer to be at work so naturally in that way, your job performance would be better."

"I'm just able to be more relaxed and more present. That's pretty hard to maintain over long periods of time without proper supports and I think this form of support [the counselling program] has probably enriched that aspect."

Theme Four:

In addition, the majority of interviewed participants stated that they believe their job satisfaction has increased due to feeling that there is more team support on the unit. This includes increasing communication on the unit between team

members and a feeling amongst the participants that they are more willing to listen to other professionals and to patients regarding patient care.

Examples:

"I think that in satisfaction, I think what's more satisfying is having, you know, the evolving support among the allies."

"Overall, there is a difference in the working relationships and the nurses who are on the unit are more open it seems."

"Well, what comes immediately to mind is [the counsellor's] ability to listen and feed it back and continually affirm you. So, I think that's really valuable for people who are suffering a loss . . . So, in my work on Palliative Care, it would be my hope to be able to communicate with people in somewhat the same way. You're always learning aren't you and it never ceases to amaze me how much more you can get just being present to people."

"Better. Must be better communication between the medical staff most times. That has room for a lot of improvement. That really does need improving but it's better."

Category Nine: The Final Question

Interviewer Question: At the end of interviews, I like to ask if there is one or two things that you want to make sure that I heard you say or that you believe really needs to be heard in this study, what would that be?

Examples:

"Well, that we need a psychologist. For us and whoever we care for. Definitely."

"I really feel that to have the kind of support that [the counsellor] has to offer and to have a person of her skill base and her personality too but certainly someone with her background and understanding I think has had a profound difference to the unit, to the way we function and the quality of the workplace as well as the quality of the care that the patients receive. I think both are really significant."

"Even with all the problems you've heard and the stresses and everything, that palliative care is still worth it. That it's still worth working in palliative care, which amazes my husband sometimes. He doesn't understand why you'd work in a place like that when there's problems with staff and all the things we've had but deep down the actual work that you do is worth it."

Why is it worth it?

"Because you're . . . I feel that you're there to do the best you can to have people have quality and comfort and be able to do the things that they're able to do for the last days, weeks, whatever of their life and you're there to reassure families that this is perfectly normal. If you want to scream and yell and you're mad at him because he's dying, go and do it. Come on in here and scream and yell and do it. And that's from feedback that we get. That they say you

don't have any idea until you need someone like you nurses. It's just satisfying. Even with all this hullabaloo. The patients and the families are the saving grace."

"I'd like you to take away that it's been a very positive thing to have [the counsellor] here and I think that different formats may be used perhaps eventually but I think it's always extremely useful to have a psychologist on board when nurses are dealing with crisis. Nurses and all staff deal with crisis much of the time."

What does 'different formats' mean to you?

"Back east, we had an RN and she had a group for nurses called "Good Grief" for nurses on a palliative care ward to go and speak individually or in a group."

"Well, I think we really need a psychologist on the unit and I think we need to . . . for me the understanding of everybody else getting what's their stuff and what's my stuff. I want people to understand that they bring . . . what they bring to the party and take ownership for it and I do my best to do that now. And I want people to learn to take ownership and not come from a victim role."

And are you seeing that change? Are you seeing people start to take more responsibility?

"Yeah. I think so. And I'm able to talk on that level, you know. I'd like to be able to spend more time with patients, just to be with patients as opposed to do . . . being as opposed to doing. That's what I'd like you to hear from me. That we need to be more present. In the moment. Right?"

"Well, I really appreciate the sessions that I've had with [the counsellor]. I think [the counsellor's] very insightful and [the counsellor's] a very good listener and you know, that's a great combination. I've been very, very happy and pleased to have the opportunity to see [the counsellor]."

"Well, I guess to be happy at work and to be a good employee

you have to be happy in life and you have to know a bit about yourself and you have to have a decent life away from your work in order to be able to come back to it with something to give and I think that if there's a way that you can help people to do that then it's a positive thing if it's through a therapist or whatever."

"Well, I guess I'm getting really hopeful. I'm getting hopeful that this will help the palliative care unit be what it should be, be what it can be because there's some amazing people, absolutely amazing people who really have changed people's lives. We have done amazing things for people. You know, we're often thanked and you know, 'Oh, you're so wonderful' and I don't mean to detract from that but sometimes it's the challenging patients who cause so much upset especially with the nurses because they're the ones who are in there twenty-four hours a day. The docs come and go, the social worker comes and goes, pastoral care, well . . . you know . . . and if anything I would like there to be some way that the nurses could be heard from that without being pointed fingers at or any of that kind of stuff that . . . because sometimes the nurses aren't being heard until it's too late, until we're really in dire straits with families, patients."

Chapter V

Discussion

The results of this investigation suggest that counselling can be beneficial for staff members working in a palliative care environment. The reported effects of the counselling intervention emphasized positive changes occurring within the participants' personal and family life, in interpersonal communications within the workplace, and intrapersonal growth and new awareness. In this final chapter, the main thematic points extracted from interviews with members of the palliative care staff are discussed. Implications for further development of the counselling consultant position within palliative care settings will be discussed, as well as implications for research, theory, and practice. Finally, study limitations are noted and followed by concluding remarks.

Convergence and Divergence in the Counselling Experience

Before beginning the counselling process, participants to the study expressed a belief that counselling would provide an increase in their self-awareness, particularly

where interactions with colleagues were involved. There was a common desire for feedback from the counselling consultant around issues of peer conflict, with participants seeking advice and reflecting on their own behaviours. Participants stated personal difficulties in addressing conflictual situations within the Palliative Care Ward and they were particularly interested in the counselling consultant working with other members of the palliative team.

This common expectation of obtaining a professional, competent therapist who was not attached to the hospital administration, and was therefore seen as being impartial by participants, was essential to many members of the study joining the counselling process. Although there was a requirement for distance between the hospital and the counsellor, participants reported the importance of seeing a counsellor who had been to the work-site and had witnessed their job environment. The counsellor's understanding of the dynamics of the Palliative Care Ward added to the element of trust and facilitated the building of relationships between the counsellor and clients.

Another common goal reported was a desire to address personal and home-life experiences that did not involve the

workplace. Participants described the counselling experience as being an opportunity for them to increase their understanding of family dynamics, interpersonal interactions, and past difficulties. Additionally, many of the health care professionals in this study sought out the counselling intervention as a means of reducing their reliance on family members, friends, and co-workers to aid them in addressing conflicts both in and out of the work environment.

Caregivers in this study reported positive results when they were asked if their expectations of the counselling process had been met by the counselling consultant. They described these expectations as being addressed through the counsellor providing them with the opportunity to express thoughts and feelings in a non-judgemental space and then following up with feedback specifically related to issues raised in session. Participants described this pattern of interaction as facilitating their ability to gain and maintain an expanded perspective on their issues. Specifically, caregivers mentioned feedback around Palliative Care Ward issues where the counsellor was able to not only supply them with individual feedback, but also

supplement this feedback with the experiences of other clients who had mentioned the same issues. Participants valued this additional perspective as it allowed them some insight into how their co-workers may perceive them in particular situations.

However, it is important to mention that there was an element of concern expressed by some members of the study around the counsellor divulging the additional perspectives of other clients within the sessions. These participants stated a concern around the confidentiality of their sessions and those of others and questioned the ability of the counselling consultant to be objective when the consultant was dealing with so many people who had multiple perspectives on the same issue. These clients expressed the belief that in other therapeutic situations, the counsellor rarely has the opportunity to hear alternate perspectives on specific incidents and these participants believed that this allowed the therapist to remain objective and focussed on the client's beliefs.

Participants, in discussing the characteristics of the counselling intervention that enabled them to participate in the study, described the location of the counselling office

as a positive factor. The internal location of the office meant that the participants did not have to spend extra time commuting to an off-site location. The location also provided the caregivers the opportunity to go for their counselling sessions before, during or after their work day. Many of the health care professionals who work on the Palliative Care Unit do not reside in the local area and have substantial commutes to work. Others stated that they did not own personal transportation and had to rely on using the transit system to get to work. Because the counsellor's office was located within the work setting, participants stated they were able to plan their counselling sessions around their work schedules, which was very convenient for them.

One of the drawbacks of having the counselling service within the hospital proper was that this placed some limitations on the confidentiality of who was attending counselling sessions. The initial placement of the counselling office was within the Social Work department of the hospital and caregivers had to wait within the office to have their sessions. Some of the participants described this as an uncomfortable feeling to have other people not

involved with the unit aware that they were there to have a counselling session. In addition, some of the study participants reported having some difficulty when the office was moved to another area of the hospital and they were not informed of the change. They described having to phone the Palliative Care Unit to find out the new location. This also compromised the confidentiality of the clients.

Participants stated that having the program provided without a fee was a very positive feature. Many of the caregivers interviewed stated that they had previously been in counselling and the reason they could not continue was that cost became an obstacle. Having the hospital fund the program was a defining factor, according to a number of participants, in making the service attractive and available. It should be noted that those participants who mentioned the positive impact of the lack of fees also stated a willingness to shoulder some of the costs for the service if the hospital administration would be willing to put some subsidies in place.

In exploring the stressful areas of working on a palliative care ward, participants expressed converging opinions. The most common stressor was trying to have their

professional opinions or perspectives of a patient on the ward heard by other health care professionals. These caregivers described feeling as though their colleagues had different agendas and that the team was not working in a cohesive fashion. The interviewees attributed this to having many strong, independent personalities working on the ward who were unable or unwilling to negotiate and discuss case issues.

A similar stress that was highly reported involved caregivers feeling judged by other health care professionals and hearing derogatory comments about themselves made by their colleagues. These participants described the work environment as tense and lacking a friendly or cordial atmosphere due to the "constant back talking" that some members of the ward engaged in. There was a lack of positive reinforcement from other staff members and from administration. Every interviewed member of the palliative team described "gossip" sessions where other, non-present staff members would be verbally attacked.

These personal and professional attacks were experienced both on an interdisciplinary and intradisciplinary level. Most of the participants reported

high levels of friction between nursing staff, allied workers, and the doctors on the ward. These incidents ranged from having disputes over job descriptions and duties, to feeling excluded from the socialization and support of another professional group. Some participants believed that other disciplines were attempting to take over their work roles and limit their presence on the ward, while others described feeling frustration that other professionals would not aid them in performing their duties when help was needed.

Dealing with the death of patients and the caregiver's own mortality was another common stressor reported by most of the interviewed subjects. When working with patients, and in particular the patients' families, caregivers reported having great difficulty when treatment plans would be continued without regard for the actual physical condition of the patients. Caregivers stated that families would continue invasive procedures even when they were either ineffective or would only prolong a painful existence for the patients. Many of the interviewed staff felt it was very challenging to deal with the desire of the family to keep their loved ones alive when there was no hope for survival.

The majority of interviewed subjects said that one of the greatest stressors associated with working on the Palliative Care Ward is dealing with the loss of patients and being present as they die. Issues arose for these participants around their own deaths, how prepared they were and how they would choose to die. Associated with this inner searching, unresolved past incidents with family members and other, close individuals were activated by the deaths of certain patients. These patients served as 'triggers' for the palliative care workers. Triggering characteristics included the patient's age, facial or physical characteristics, personal demeanor, lifestyle, occupation, etc.

These unresolved personal experiences were one of the three major issues that the interviewed subjects identified as being central in their counselling work. Participants alluded to specific incidents with patients that had been problematic for them in either facing their own death or that of others they had experienced in the past. These fears were addressed along with the more global issues of how to cope with sadness and loss within their lives. Caregivers related experiences where they had become particularly close

with certain patients and this caused them to have, in some cases, great difficulty finding closure after the patient's death.

An equal number of the interviewed participants asserted that the main issue that brought them to counselling was around difficulties in relationships with family members, friends and acquaintances that. Some of these participants described feeling a connection between their home life and work life. Personal problems also altered the caregiver's ability to focus on patient concerns and provide the level of care they aspired to or were capable of. They expressed a desire to heal their home life initially and they believed that this would have a positive impact on their job performance and work environment.

The final issue that was identified as being a central concern for the caregivers who participated in the counselling intervention was a lack of effective communication between staff members on the Palliative Care Ward. The palliative care unit operates within a team framework and many of the interviewed participants felt that the team was being separated and divided by a tense environment and a lack of cohesion between staff. These

caregivers sought out the counselling intervention as a means of devising more effective methods of communicating with their colleagues. They felt that they did not possess the necessary skills to be able to successfully counteract the negative atmosphere they were experiencing in the work environment.

In terms of the changes that the participating individuals experienced from the counselling intervention, these were investigated on three levels: 1) personal issues and home environment, 2) work environment and interaction with colleagues, and 3) job satisfaction and job performance.

Participants reported increased feelings of self-awareness around their personal issues. They were also more able to establish appropriate boundaries. They described part of the change as being able to distinguish their personal problems and concerns from any work related difficulties they were encountering or had previously dealt with. This included being able to identify areas of their own life that were unresolved or unfinished and separate them from their interactions with patients. This separation allowed some of the participants to alter their views of

patients and colleagues and to identify where some of their reactions and feelings were originating.

As a result of new awareness and recognition of previous issues or life patterns, participants experienced feeling stronger bonds between themselves and their family members. They were able to confront and cope with issues in their home and personal lives more immediately instead of storing their feelings up and releasing them in inappropriate situations or responding to trying circumstances in an exaggerated or overstated manner.

Participants also described being able to leave issues and problems that they experienced during their working hours behind when they were going home. They stated that discussions around general work topics still took place but they described the difference as a lack of a need to unload their work-related issues within their home environment. This allowed the caregivers to become more objective when dealing with home issues and difficulties and consequently lessening the tension within their home and personal life.

Finally, the majority of the sampled caregivers stated that they were beginning to make a more concerted effort to take care of their personal health and emotional well being.

They attributed an overall improved feeling of health to working with the counselling consultant. They described being more physically fit and not as fatigued as they were prior to participating in the counselling intervention. This also involved feeling physically more able to work on the unit and to reduce their need to use mental health days to regenerate themselves.

With regard to changes in the participant's work environment and / or their interactions with colleagues, the majority described an increased awareness of dynamics between themselves and their colleagues on the Palliative Care Ward. They began to address issues or problems when they occurred instead of following the previous pattern of avoidance.

Additionally, some participants reported becoming aware of when to engage in a situation in the workplace and when to step back from it. They found themselves dealing with issues in which they were personally involved and avoiding those conflicts that did not involve them directly.

Many of the caregivers stated that they were feeling as though there was less negative energy and tension in the workplace. This atmospheric change had the positive effect

of increasing their desire to be at work and reducing their urges to quit their positions, transfer to other areas of the hospital or avoid the unit through use of sick-leave. They believed that one of the major components of this energy shift was due to feeling more listened to by their colleagues around issues of patient care and unit organization. Consequently, these participants stated that they were more willing to listen to the opinions of their co-workers and to discuss many of the problems on the ward in a less defensive manner. The result of more open communication was an improvement in patient care and a greater ability to work cohesively as a team within the Palliative Care Unit.

Most of the study participants also described their colleagues being friendlier. They noted a decrease in the number of arguments and conflicts between staff members, and they stated that the level of gossiping and discussion of absent colleagues had been reduced significantly during the counselling intervention.

In terms of changes that the participants experienced in their levels of job satisfaction and job performance, the majority reported that they felt happier with themselves and

that they did not feel as depressed as they had before the counselling intervention. They expressed the opinion that this alteration in their mood and demeanor was the result of looking forward to coming to work on the Palliative Care Unit instead of fearing or dreading their work days. Some participants linked their job performance to their job satisfaction stating that they believed patient care had been improved by the decrease in tension among the staff members.

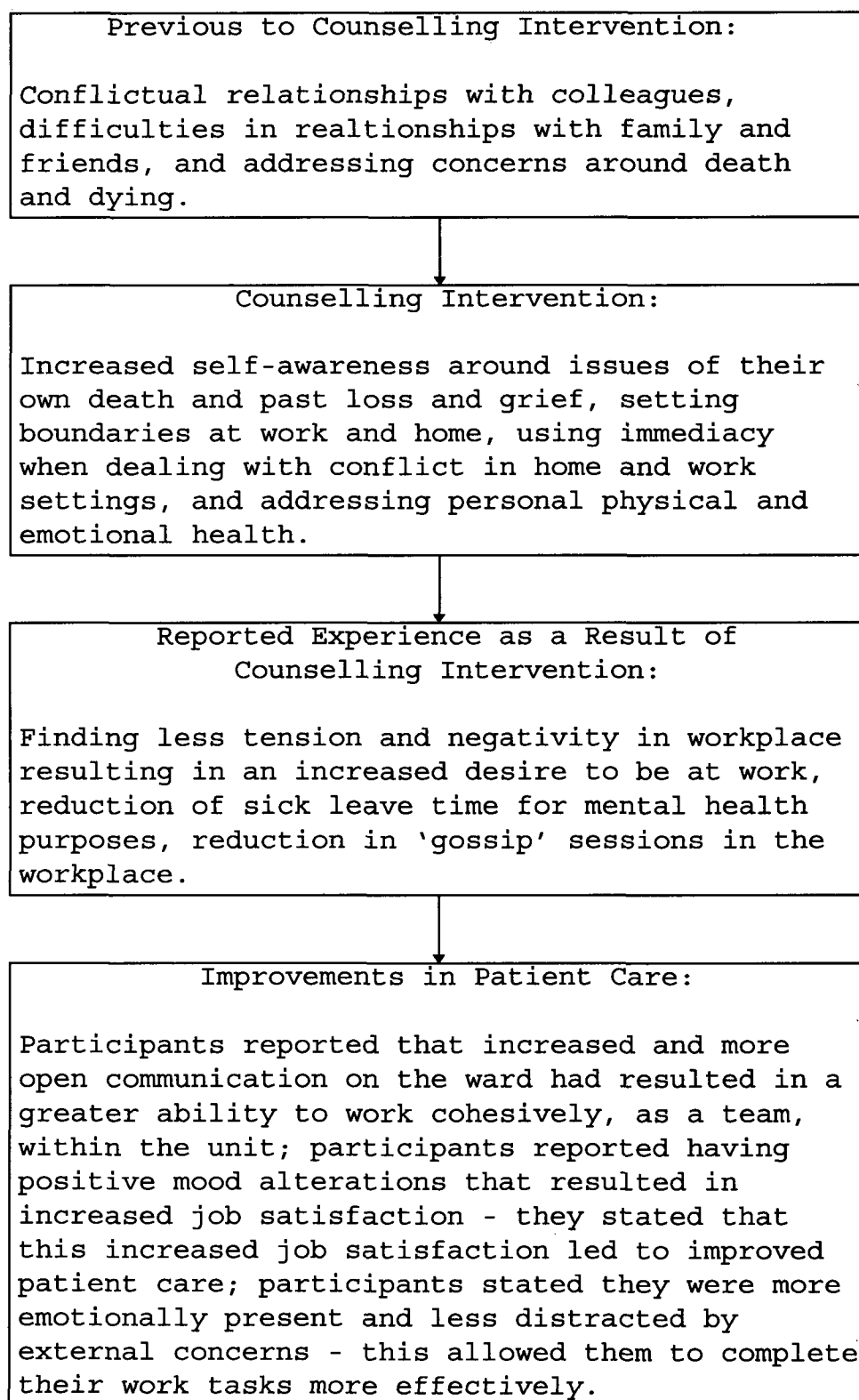
The majority of those clients who were interviewed stated that the decrease in conflicts between colleagues has allowed them to relax in their work and to be able to direct their energy to patient care. They reported feeling more emotionally present and less distracted by external issues or concerns and as a result they found themselves able to complete their work more effectively.

The availability of counselling has provided a 'release valve' for the staff in that it gave them a safe environment to discuss any problems or concerns. In turn, the participants stated that this is allowing them to refocus their attention to the needs of patients and their families.

Job satisfaction had also risen as a result of an

increase in team support on the unit. This support included increasing communication on the unit between team members and a feeling amongst the participants that they were more willing to listen to other professionals and to their patients regarding patient care.

Table A: Reported Caregiver Experience Throughout
Counselling Intervention



Implications for Future Research

The present study supports the value of further pursuing and exploring the potential of a counselling intervention, on a long-term basis, for the use of staff members working in palliative environments. Future evaluation would be well served by utilizing both quantitative and qualitative methods of assessment.

In addition, including larger numbers of participants would serve to expand the data set and provide a larger picture of the effect of such an intervention. Including such stakeholders as the counsellor, physicians, and male staff members may also provide a more complete study. Patient interviews may also contribute to the data set in terms of any changes they had experienced in their interactions with hospice staff.

The researcher believes that conducting a longitudinal study may also provide a more objective view of the effect of the counselling intervention. Having access to administrative data such as sick leave numbers during the time previous to and during the intervention could have been effective at displaying any fiscal and health benefits of the counselling service.

Theoretical Implications

The present study lends support for the efficacy of a counselling intervention for health care professionals that work with terminally ill patients. The increase in job satisfaction, effectiveness in participant's communication in both home and work environments, participant's reports of better physical and psychological health all support the counselling intervention.

The data set reflects Vachon's work (1987; 1988) on occupational stress for palliative caregivers and adds to the coping strategies that health care professionals can use to reduce stress and risk of burnout. Additionally, study results reflect Danbury's (1996) investigation of bereavement counsellors, specifically in discussing the necessity for healing unresolved traumas when working with terminally ill patients. Without the availability of a healing environment, professionals that work with palliative patients risk falling into a state of perpetual grief. The consequences for this may include reduced job satisfaction, job performance, and patient care.

This study builds a foundation into exploring the possible benefits of counselling interventions for all

health care professionals who work in traumatic environments. Previous coping strategies for this population do not address individual counselling with a trained professional as a viable intervention, choosing instead to focus on supervisor facilitated groups, biofeedback exercises, peer counselling, etc. The results also reinforce the ability of counselling to affect meaningful change in a relatively short period of time. This allows counselling to continue to be a viable intervention during times of fiscal restraint in the medical community.

Practical Implications

There is a need, as expressed by the participants in this study, for some form of intervention that will:

- facilitate more effective communication between co-workers
- address personal issues of loss and bereavement around patients and unresolved issues from past losses
- provide caregivers with coping strategies that address

the stressors involved in interacting with dying patients and their families

Services that address these issues are abundant within the metropolitan area of Vancouver, yet may not be a known commodity among health care professionals. If the counselling consultant intervention demonstrated in the Palliative Care Ward of St. Paul's Hospital is not a viable option, there are other counselling services that may address the needs of hospice caregivers. For instance, Employee Assistance Plans provide a number of counselling sessions at a reduced rate and are generally located within the immediate vicinity of the employer. Extended medical benefits provide funding for counselling sessions through Registered Psychologists. Family physicians may also provide referrals to psychiatrists who can help with any mental health needs and local agencies provide counselling services on sliding fee scales. These services are available to palliative caregivers but may not be well known.

Programs that address the major concerns expressed in this study may also be implemented by hospital administration. For example, group meetings facilitated by

professional counsellors could be initiated to run on a bi-weekly or monthly basis. These could be focused on addressing communication between disciplines and amongst nurses, doctors and allied health professionals.

In addition, psycho-educational groups and conferences could be sponsored by the hospital administration or health care unions to provide self-care techniques for controlling stress levels. Peer counselling could also be formed within or between wards within the hospital to ensure the presence of support networks for health care professionals.

Limitations

First, the sample used was not randomly selected. Selection bias is always a factor when self-selection methods are employed. Although this study may suffer criticism due to having few participants, a lack of gender representation, and lacking physician or counsellor participation, its purpose has been to provide qualitative data on the impact of an innovative intervention. Future investigations would benefit by expanding the sampling methods used here.

Another potential limitation is the self-reporting

method for impact assessment. As the counsellor introduced the research section of the study, there may be suggestions of personality factors skewing the results. For instance, a caregiver who found the intervention to be successful may be more inclined to discuss their experience when asked than a participant whose experience was not as positive.

The researcher is also concerned with the possible impact of cross-referencing that occurred within some counselling sessions. Participants stated a concern that counsellor objectivity may have been compromised through the use of feedback that included opinions or perspectives of other clients who were using the counselling service. They reported being curious about the ethical considerations of this practice and this may have affected their belief in the confidentiality of the counselling environment.

This study may further have been compromised due to a restructuring process that occurred concurrently to the counselling intervention. A number of caregivers, during the period of the study, either retired from the palliative care ward or relocated to other areas of the hospital. In addition, a nurses' strike took place towards the final month of the intervention and may have affected the

emotional and financial state of some of the interviewed subjects.

Finally, the study may have been limited due to the implementation of new policies within the palliative care unit. Staff retreats were scheduled to enhance worker communication and to discuss past events on the ward, group sessions were initiated to serve a similar purpose, and a new work schedule was implemented that altered the hours that some health care professionals spent on the ward. The researcher believes that worker relocation and retirement do not pose a major factor in the results of this study. However, there is less certainty about the effects of the group retreats and group sessions that were initiated due to the suicide of a palliative team member approximately eight months before the counselling intervention took place.

Conclusion

This study investigated the perceptions of process and impact that a counselling intervention had upon the health care professionals of a palliative care ward. Participants engaged in one-to-one counselling sessions that ranged from eight to twenty appointments through the duration of the

counselling intervention. Sessions involved the counsellor and participant discussing issues relevant to the participant's home or work life and were not limited in their scope. Eight health care professionals were involved in this study. They included five nursing staff members and three members of the allied health professional team (i.e. music therapist, occupational therapist, pastoral care, social work, etc.). All of the participants were women.

Results indicated that participants felt there had been significant changes within their own behaviours as well as amongst their colleagues on the ward. These changes generally involved a positive alteration in communication with co-workers, changes in personal attitudes towards work, family and friends, and an increase in job satisfaction that led to improved job performance and patient care.

Participants found the counselling service accessible and useful as a means of increasing their self-awareness of their home and work lives. The location and hospital subsidization of the service were encouraging factors for participants to attend counselling sessions.

The counselling consultant intervention has demonstrated considerable promise in addressing the needs of

health care providers in palliative care environments. While there is grief and loss experienced throughout entire hospitals, palliative care is unique in the quantity and effects of such losses. Working with terminally ill patients requires personal attention and attachment on a different level from any other unit in the hospital system. The caregivers' task is to provide a good death, preparing people to die and having to cope with the family, friends and patients who cannot yet let go. The counselling intervention is essential in providing this specific, unique group of caregivers a venue to release and express their experiences of the dying process. Without such an intervention, the quality of care for the patients and their families is severely compromised.

The results of this study show a clear need for an intervention that has the ability to access both personal and professional difficulties in a safe and open environment. The counselling consultant model has addressed these issues and therefore merits further attention, evaluation and investigation.

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