

ROLE AMBIGUITY, ROLE CONFLICT OR BURNOUT: ARE THESE AREAS OF CONCERN FOR AUSTRALIAN PALLIATIVE CARE VOLUNTEERS? PILOT STUDY RESULTS

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ABSTRACT

OBJECTIVE: To determine if burnout, role ambiguity or conflict affects Australian hospice volunteers.

METHOD: Hospice volunteers (n=120) participated in this survey.

RESULTS: 97 participants completed the survey. The majority were middle aged women who had been palliative care volunteers for more than 7 years and volunteered 14 hours/week (median).

Participants reported low levels of role ambiguity ($X=8.4$, $SD \pm 3.0$) and conflict ($X= 9.8$; $SD\pm 3.4$) and described enjoying their volunteering and having no symptoms of burnout (76%).

SIGNIFICANCE: Whilst burnout and role ambiguity were not identified as areas of concern for these volunteers, hospice services need to be mindful of the potential for role conflict. Adopting a range of self-care strategies and working within a structured volunteer program appear to be important protective factors.

The demand for hospice volunteers is expected to increase in line with the growing numbers of older people with chronic diseases.¹ Identifying and managing the factors that impact on volunteer recruitment and retention will be increasingly important for hospice services in order to maintain this valuable and integral resource.² It is estimated that up to 43% of hospice volunteers' end up relinquishing this role within the first two months.^{3,4} Largely due to personal factors associated with a career, illness and family, geographical relocation and/or service based issues.⁵ Repeated intense personal encounters with dying patients and their families or 'burnout' is a potential risk factor for volunteer attrition.⁶⁻⁸ Although not currently recognised as a psychiatric condition, 'burnout' is characterised as a psychological syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment.⁹ Mental, physical and emotional symptoms, such as insomnia, worry or headaches may be early warning signs of burnout.¹⁰ Despite being common in many professions outside of health, cancer and hospice clinicians are at higher risk of developing burnout as a result of specific stresses inherent in their roles.^{11,12}

A 1997 US study exploring burnout and job satisfaction among hospice volunteers, reported a strong negative correlation between burnout and training preparation, sense of team involvement, satisfaction with supervision, and overall job satisfaction.¹³ A more recent US study identified volunteer training, educational opportunities, communication training, and emotional support for staff and volunteers minimise the impact of burnout on the effectiveness and efficacy of the hospice program.¹⁴ A 2012 Australian study investigated hospice volunteer burnout and connectedness in the job across 18 services, and identified that even though some volunteers may experience high levels of emotional demands, work-home conflict, conflict with staff, and feeling overly exhausted, these factors do not necessarily lead to attrition.² Good supervisory support, maintaining connectedness and minimising cynicism in the volunteer work environment were all identified as potentially having a stronger impact on volunteer retention than exhaustion alone.²

While role ambiguity and role conflict are associated with attrition in the paid workforce¹⁵, few recent studies have explored the impact of these factors on the hospice volunteer workforce. The potential for role ambiguity and role conflict has increased as organisations have become more complex and routine tasks are increasingly distributed among team members, whose roles are often already blurred.¹⁶ Role ambiguity pertains to the expectations surrounding a role, and occurs when the set of behaviours required for a role are not clearly defined.¹⁶ People experience role ambiguity if there is a lack of clarity about their expected role behavior, responsibilities and performance criteria.¹⁷ Role ambiguity has been identified as a major factor in contributing to stress experienced by hospice volunteers, particularly in relationship to their uncertainty about: what activities they were permitted and not permitted to undertake, whether to attend team meetings, provide hands-on care, and the type of information they can share with the patient's treating physician.^{18, 19} Inadequate training, poor instructions, limited access to support and infrequent reviews may also contribute to role ambiguity for volunteers. Role conflict occurs when there is incompatibility between the expected set of behavioural demands on an individual and their actual performance.¹⁶ Role conflict may occur if the volunteer role creates personal pressure(s), performance is called into question, if they accept roles beyond their capacity or if they feel they do not have the power to say 'no' to assignments.¹⁸ If volunteers perceive their role obligations as being vaguely irritating, difficult, conflicting or impossible to meet, over a prolonged period these feelings may become problematic and contribute to burnout.^{15, 17} Despite, these inherent risks the degree to which role ambiguity and role conflict affects the palliative care volunteer workforce is yet to be fully investigated.

Rizzo's Role Conflict and Ambiguity Scale

Rizzo's Role Conflict and Ambiguity Scale¹⁵ (Rizzio's Scale) explores the relationship between role ambiguity and role conflict in the workplace against measures of organisational and management practices, leadership behaviour, satisfaction, anxiety and propensity to leave a position. A meta-analysis of this role conflict and ambiguity scale found that organisational context variables such as

task/skill variety, autonomy, leader initiating structure and feedback from others were strongly related to role conflict and ambiguity, while individual characteristics were not.¹⁶ Despite Rizzio's Scale widespread application with paid workers, no evidence of its use with a volunteer workforce was identified.

Objectives

The objectives of this pilot exploratory survey were to identify if there was any evidence that Australian hospice volunteers were experiencing role ambiguity, role conflict or perceived that they were burning out as a result of their volunteering role and to gain insights into the prevention strategies adopted by these volunteers to prevent burnout.

Methods

Study design, setting and participants

This pilot survey was undertaken in partnership with the two Australian hospices in Sydney NSW, with similar historical origins, organisational structures and bed numbers. Both services provide inter-disciplinary inpatient and community based hospice care, as well as having comparable volunteer programs. At the time of this study 120 active volunteers were registered across these two services. Invitations to participate in the survey were sent out to all volunteers registered with the two palliative care services by the volunteer managers.

Ethics

Ethics approval was obtained from The University of Notre Dame, Australia Human Research Ethics Committee. The study complied with the Declaration of Helsinki ethical rules.

Hypothesis

It was hypothesised that Australian hospice volunteers working within a structured volunteer program would report low levels of role ambiguity, role conflict or burnout and have adopted a range of burnout prevention strategies.

Survey instrument

As no validated volunteer role ambiguity, conflict or burnout questionnaire was identified, the data were collected using several instruments, which allowed for the collection of: i) volunteer socio-demographic data²⁰; ii) role conflict and role ambiguity data using a modified Rizzo's Scale¹⁵; iii) data from a single-item question measuring self-defined burnout,²¹; and iv) qualitative data from three open-ended questions, exploring the 'best' and 'worst' aspects of being a palliative volunteer²⁰ and to identify the burnout prevention strategies adopted by volunteers.

The modified Rizzo's Scale was pilot tested with a sample of hospice volunteers (n=5), to ensure relevance and acceptability. As a result of the pilot, three statements were omitted and minor changes were made to one statement to better reflect the volunteer role. In the final scale participants rated the frequency of volunteer role ambiguity [5 statements] and role conflict [6 statements] on a 5- point Likert-type scale ranging from [1= never] to [5 = very often]. The role ambiguity statements were re-coded, generating a summated mean score of between 5 [low] and 25 [high].¹⁵ The role conflict statements were also summated generating a mean score of between 6 [low] and 30 [high]. Using the full study sample, a Cronbach alpha of 0.69 is reported for the 6 item role conflict and 0.78 for the 9 item role ambiguity sub-scales, indicating acceptable internal consistency reliability.²³

The 'self-defined burnout' question allowed participants to define their own level of burnout. This single question has been demonstrated to have moderate to high correlation with the emotional exhaustion component of the validated Maslach Burnout Inventory with cancer care clinicians.²²

Participants were asked to select which response best define their level of burnout: 1) *I enjoy my volunteering. I have no symptoms of burnout;* 2) *Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out as a result of my volunteering work;* 3) *I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion, as a result of my volunteering work;* 4) *The symptoms of burnout that I'm experiencing won't go away. I think about my frustration with my volunteer work a lot;* or 5) *I feel*

*completely burned out and often wonder if I can go on volunteering. I am at the point where I may need some changes or may need to seek some sort of help.*²² Responses were then categorised into 'Low' [Response 1], 'Moderate' [Response 2] or 'High' [Responses 3-5].²² The final section of the survey included the following three open-ended questions: i) what is the best part of being a palliative care volunteer? ; ii) What is the worst part of being a palliative care volunteer? ; and iii) What are your recommended burnout prevention strategies?

Bias and study size

The sample is from two palliative care services so the results may not be reflective of all Australian hospice volunteers.

Data collection and analysis

Participants had the option of completing the survey on-line (via Survey Monkey) or as a hard copy which was then manually entered into Survey Monkey.

Quantitative variables: All data was analysed using SPSS V.18. Descriptive statistics were used to explore the demographic (age, gender, postcode, employment status) of this population, as well as the activities undertaken as specialist palliative care service volunteers. After the role ambiguity and role conflict statements were re-coded to be negative, the scores for each factor were separately summated with a higher score indicating a higher level of role ambiguity or role conflict.¹⁵ All quantitative results were verified by a bio-statistician.

Qualitative variables: The qualitative data generated by the open-ended question exploring the best and worst aspects of volunteering and burnout prevention strategies was analysed using thematic content analysis. The data was categorised using deductive derived codes, which were grouped together according to emerging themes.²³

Results

Sample

The majority of eligible participants completed the survey (n=97), representing a response rate of 81%. As there was no difference between the two recruitment sites in terms of gender ($\chi^2=0.001$, df 1, p =0.976) or age (t= -0.548, df 95, p = 0.585) the data sets were combined.

Descriptive data: Most participants (84%) were female, with a mean age of 61.7 years ($SD \pm 11.2$). A third (33%) identified as being from a culturally and linguistically diverse background. No one identified as being an Australian Aboriginal. Over half (54%) were retired, with just less than a third (30%) employed either on a full or part time basis (Refer Table 1).

The majority had been hospice volunteers for a median of 6.6 years (*IQR* 2.3 to 10.6 years) and contributed a median of 14 hours (*IQR* 8.5 to 20 hours) volunteer hours per month. Over half (60%) planned to continue in this role for years. The majority (91%) volunteered weekly during office hours and two thirds (61%) had previous volunteer experience, predominately in the community or welfare sector (23%). Most had undertaken formal volunteer training (68%) and had direct patient contact (78%).

Table 1: Summary of participant demographic data and volunteer factors

Demographics and volunteer factors		Sample	
		N (97)	100 (%)
Age \bar{X} (SD) years		61.7	(+ 11)
Gender	Female	82	84
	Male	15	16
Cultural Background	Ethnic identity	32	33
	Aboriginal or Torres Strait Islander	0	0
Employment status	Full-time	6	6
	Part-time	23	24
	Unemployed/seeking employment	1	1
	Student full-time	5	5
	Student part-time	1	1
	Not in labour force (Retired)	52	54
	Not in labour force (other)	9	9
Previous volunteer Experience	Community/welfare	22	23
	Religious	16	16
	Other	12	12
Motivations for volunteering	Knew their contribution would make a difference	70	72
	Had a personal belief for the cause	63	65
	Lived close to the volunteer site	20	21
	Agreed with the organisation's values and principles	46	50
	Felt they would have personal growth from the role	53	55
	Wanted to be active	30	31
	Wanted to use their skills/experience	39	40
	Wanted to learn new skills	28	29
	Wanted to gain work experience	8	8
	Had past experience in a palliative care context	19	20
	Other reasons	12	12
Volunteer training	Formal training program	66	68
	Informal/on the job program	19	20
	Did not receive	12	12
Volunteer activities undertaken	Direct patient contact	76	78
	Hospital/hospice based support/activities	67	69
	Home based visits	23	24
	Other duties	16	17
	Recreation/leisure activities	14	14
	Shopping assistance	10	10
	General assistance with transport	9	9
	Assistance to doctors	3	3
Plans to Continue Volunteering	For years	58	60
	For a year	4	4
	For less than a year	0	0
	I don't know. It will depend on how I feel about it throughout my volunteer experience.	6	6
	I don't know. It will depend on other things happening in my life	23	24
	I don't know. For other reasons	6	6

Best and Worst Aspects of Palliative Care Volunteering

The opened-ended question about the 'best' and 'worst' aspects of being a palliative volunteer provided insights into the predisposing, enabling and/or reinforcing factors shaping the volunteers experiences of role ambiguity, conflict or burnout (Table 2). The majority of participants (87%) described the best aspects of volunteering as being linked to the rewards associated with unpaid work, with (80%) nominating 'making a positive contribution' as an important driver: *'I am able, regardless of my age, to assist palliative patients and their carer (if they happen to be in the room) with my decades of experience...I leave...feeling grateful for the privilege of having been able to assist those most in need of 'relief' in a 'tangible' manner'* (Participant #14). A smaller proportion (20%) described the rewards of 'worthwhile relationships' – *'Being part of a team dedicated to the(se) high principles, (and) through that, helping a patient feel the love and support he/she deserves'* (Participant #60). A smaller proportion of participants (67%) provided responses for the 'worst' aspects of volunteering', with the most common theme related to 'Dealing with suffering' (69%) - *'Forming a relationship that is obviously finite...witnessing the suffering of patients and family alike'* (Participant #69). A smaller proportion of participants described fears of 'making mistakes' (14%) - *'Doing the wrong thing/making a mistake about care of patient'* (Participant #48). A few participants commented on the challenges of conflicting commitments (9%) – *'Occasionally something happens at home that has to be taken care of when you have committed to be with the palliative care patient'* (Participant #83); and 'not being valued' (8%) - *'A little courtesy and a smile from the nurses would go a long way to making us feel useful and that we have helped'* (Participant #84).

Table 2: Suggested burnout prevention strategies (n=148)

Themes	Strategies to prevent burnout
Self-care strategies (49%)	<ul style="list-style-type: none"> • 'Take time out to refresh' – 'Taking a few weeks off' • 'Tune out from my manager and seek my own counsel' • "Maybe reducing hours if a volunteer is suffering burnout" • 'Involvement in a variety of activities – not tied to one place or responsibility' • 'Ask the question, 'How do you perceive death?'. If needed, detach on the journey home' • 'Enjoy and indulge your passions'
Reaching out (27%)	<ul style="list-style-type: none"> • 'Talk to someone about it' • 'Seek professional help to discuss my concerns' • 'Debriefing after each roster with a 'qualified' manager' • 'More supervisor - volunteer contact" - Regular debriefing' • 'Good communication between volunteer and coordinator' • 'Support group where everything is discussed'
Valuing the role (24%)	<ul style="list-style-type: none"> • 'Limit the amount of hours per week a person can volunteer' • 'Formal training sessions on all aspects of palliative care' • 'Feedback from patients, nurses, family or doctors the value added element a volunteer contributes to the patients' • 'Verbally thanking volunteers at the end of a shift' • '...better support from paid staff' • 'Some understanding from staff that volunteers come from varied backgrounds with valuable experience'

Role Ambiguity, Role Conflict and Burnout

Participants' responses to the modified Rizzo's Scale¹⁵ revealed low levels of role ambiguity Median 8 (IQR 6-10) (\bar{X} =8.6, $SD \pm 3.7$) and role conflict median 9 (IQR 7-12) (\bar{X} = 9.8; $SD \pm 3.4$). The majority (76%) of participants self-reported having low levels of burnout, with a fifth (22%) acknowledging having moderate levels of burnout. All participants provided at least one burnout prevention strategy generating a large number (n=148) of suggestions categorised into three major themes: i) 'self-care strategies' (49%), 'defined as the care of oneself without professional assistance or oversight'; ii) 'reaching out' (27%); and iii) 'valuing the role' (24%).

Discussion

Role ambiguity, role conflict, and burnout do not appear to be major areas of concerns for these hospice volunteers. The rewards associated with hospice volunteering, such as '*making a positive contribution*' and having '*worthwhile relationships*' outweighed the costs associated with '*dealing with suffering*' and '*making mistakes*'. It would seem that making a difference, acceptance, support and companionship were much greater rewards than the costs of undertaking hospice volunteer work.² This reality may in part be explained by Social Exchange Theory, where relationships are based on negotiated exchanges, shaped by costs, benefits, and shared obligation between others.^{2, 24} This theory may also explain volunteers' enduring commitment to the role and their willingness to regularly devote substantial time to this unpaid work, and their low self-reported levels of burnout.²

Low rates of burnout

The low rates of self-reported burnout in this study is in contrast to the higher burnout rates reported amongst cancer and hospice clinicians, which may reflect additional demands placed on professionals in paid positions.^{12, 25} Volunteers also work fewer hours per week compared to paid clinicians and their role is a social rather than a business transaction and affords greater flexibility and freedom.¹ Given these protective factors it is not surprising, that unlike clinicians, very few volunteers in this study indicated that their own health or well-being was contributing to feelings of burnout.¹² In addition, people who self-select to become hospice volunteers are likely to have personality traits which enable them to better cope with the demands of this role,²⁶ and also protect against burnout.²⁷ Whilst volunteers often identify instances that were temporarily stressful, few perceive that this exposure leads to prolonged stress.^{28, 29}

Prevention strategies

Hospice volunteers in our study recommended a range of burnout prevention strategies, including the importance of self-care and reaching out to others. Similar to hospice clinicians, adopting self-

preservation strategies allowed these volunteers to consciously identify and undertake activities that optimise the use of their finite personal resources, protecting their longer-term volunteering capacity.⁷ A combination of engaging in a range of self-care strategies, including being selective in their volunteer activities along with not being clinically responsible for patients, appears to help minimise the intensity of this unpaid work. Personal growth and volunteer rewards combined with a concomitant belief in a palliative philosophy have previously been identified as being protective against potentially stressful volunteer experiences.^{30, 31} The importance of adopting a range of physical, psychological and emotional self-care strategies, along with reaching-out and seeking spiritual support have all been previously identified as important burnout prevention strategies.⁷

The higher levels of burnout noted among cancer and hospice clinicians is associated with higher attrition from the clinical area or intention to leave the profession.²⁵ In contrast, few volunteers in this study planned to leave their volunteering role, conferring a level of satisfaction with the role, which is congruent with the low levels of reported burnout. Previous research has noted that even when hospice volunteers feel emotionally drained they frequently exhibit few signs of depression and are more than likely to continue in the role than resign.² However, the degree to which burnout actually contributes to volunteer attrition remains unknown as it is likely that volunteers, similar to health professionals, may simply leave the service or ‘drift away’ from the volunteer role when they feel burnt out. Exit interviews with volunteers leaving the service would provide valuable insights and would help determine if role ambiguity, conflict, or burnout were contributing factors.³²

Overall these volunteers had few concerns, other than dealing with loss and suffering. For a smaller proportion, on occasions not being valued and a perceived need for additional volunteer training were the only other items raised by some volunteers as an area of concern. Whilst these numbers were small, volunteers not feeling valued is a reminder of the importance of the team acknowledging their contribution to patients’ well-being.³³ Hospice volunteers may feel rejected if their need for meaning, belonging and fellowship is not met.³⁴ The extent to which feeling disconnected from the

hospice team or not being appreciated underpins hospice volunteers decision to resign requires further exploration.² Similarly, a small proportion desired more training.

Adequate training ensures that volunteers: feel confident dealing with issues surrounding death and dying; are better prepared to personally cope³⁵; understand the need to maintain service quality;³⁶ are familiar with their roles and responsibilities; are part of a peer support network; and establish a rapport with the volunteer coordinator.⁵ Having a well prepared volunteer workforce who understands the complexity of the hospice operating environment and is able to cope with the demands of the role is critical. The commencement phase of hospice volunteering is the most stressful stage for new recruits as they learn to deal with challenging situations or events.²⁹ The small proportion of volunteers who had not received any volunteer training requires further exploration, especially given that this training was mandatory in these services because of the demands of this unpaid role and the complexity of the operating environment.

Limitations

The cross-sectional nature of the study means that casual inference cannot be made. The modifications made to Rizzo's Scale for this volunteer workforce requires further validation. As burnout was unlikely to be a major concern for active volunteers, the single item self-defined burnout question²² was considered an appropriate screening tool. However, as the volunteers were asked to self-define 'burnout' it is likely they have each applied different criteria and definitions, but this cannot be confirmed. The extent to which these volunteers engaged in respite care was not captured by the survey activity codes, which is unfortunate as respite care has been identified as one of the most highly valued services that hospice volunteers can provide.³⁷ As the survey was only distributed to current hospice volunteers it does not reflect the experiences of ex-volunteers, so the results may be biased as a result of their exclusion. Finally, as this survey only involved two large metropolitan hospice services in one Australian State it may not reflect the views of volunteers in other jurisdictions, regional areas or those working with smaller services. However, the

demographic profile of this cohort mirrors that of other hospice volunteer studies,³⁸ conferring some confidence in the representativeness of the sample, but this cannot be confirmed.

Conclusion

As volunteers are a valuable and integral resource within hospice service it is essential that there is continued research exploring their role. Whilst burnout and role ambiguity were not identified as areas of concern for these volunteers, hospice services need to be mindful of the potential for role conflict. Operating within a structured volunteer program helps minimise these risks by ensuring that volunteers are adequately prepared and supported in their roles, have access to ongoing training and are supported and encouraged to engage in burnout preventative self-care strategies. Undertaking a larger national study and validating the questionnaire is an important area for future research. This exploratory study provides baseline data to inform future research into volunteer's roles.

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