

*Prosocial motivation and
mental health in hospice care
volunteers – a grounded theory*

Thesis

submitted in partial fulfilment of the degree requirements

**Master of Science
Psychology**

Christian Schulz

First supervisor: prof. dr. Gerben Westerhof
Second supervisor: dr. Peter Stegmaier

Faculty of Behavioral, Management and Social Sciences (BMS)

**UNIVERSITY
OF TWENTE.**

Enschede, 27.01.2021

ABSTRACT	3
INTRODUCTION	3
HOSPICE CARE – A HISTORY OF VOLUNTEERISM	4
ASSESSING VOLUNTEER MOTIVATIONS	6
DEFINING MENTAL HEALTH	10
RESEARCH QUESTION	11
METHODOLOGY	12
DESIGN AND REFLEXIVITY	12
INTERVIEW AND MATERIALS	14
PARTICIPANTS	14
DATA COLLECTION	15
DATA ANALYSIS	16
MEMBER CHECK	17
RESULTS	18
DESCRIPTIVE SUMMARY MEMO	18
CATEGORY 1 – THE LEARNING JOURNEY	23
CATEGORY 2 – THE CULTURE OF DYING	25
CATEGORY 3 – THE VOLUNTEER	27
CATEGORY 4 – PURE-ALTRUISTIC VOLUNTEER MOTIVATIONS	30
CATEGORY 5 – PSEUDO-ALTRUISTIC VOLUNTEER MOTIVATIONS	32
CATEGORY 6 – THE CLIENT-VOLUNTEER RELATIONSHIP	34
CATEGORY 7 – THE ORGANIZATION	37
CATEGORY 8 – THE VOLUNTEER-ORGANIZATION RELATIONSHIP	39
CATEGORY 9 – MENTAL HEALTH AS A RESULT OF RESOURCE EXCHANGE: FEAR-REDUCTION AND APPRECIATION	41
MEMBER CHECK	45
DISCUSSION	47
EXCHANGE PROCESSES AS A LACKING DIMENSION IN QUANTITATIVE MEASURES	47
UNDERSTANDING APPRECIATION AS A POSITIVE RESOURCE	50
LIMITATIONS AND WEAKNESSES	52
IMPLICATIONS FOR PRACTICE	54
CONCLUSION	55
APPENDIX A: INTERVIEW SCHEME	56
APPENDIX B: INFORMED CONSENT	58
REFERENCES	59

Abstract

The study describes the idiosyncratic experience of mental health in non-professional hospice volunteers in relation to their motives and strategies for volunteering using a constructivist grounded theory paradigm. Participants were obtained by convenience sampling and interviews were dynamically adapted to the concepts brought up by the participants using theoretical sampling. Results indicate that volunteers are usually motivated by both true- and pseudo-altruistic motivations at the same time and experience their work as a relational resource exchange process between their group cohort, their hospice organization and their clients characterized by the mutual exchange of appreciation as the central process between all actors: volunteers donate time and receive knowledge, feedback and appreciation back from the organization; in contact with clients, volunteers again donate time and emotional availability against receiving appreciation from their clients. Appreciation exchange impacts volunteer's mental health by fostering perceived self-efficacy and the reduction of personal fear. The concept of appreciation exchange closely corresponds to the role of positive relations with others in Ryff's (1978) theory-guided dimensions for psychological well-being that describe positive psychological well-being as a function of successful inter-personal give-and-take relationships. The present study concretizes the notion by providing a theoretical model for appreciation exchange in hospice contexts grounded in the idiosyncratic social reality of the volunteer. Furthermore, all motivational dimensions from existing quantitative measures on volunteer motivations - IMHPCV and VFI - were confirmed in the data. However, results indicate that while these measures appropriately depict volunteer motivations prior to starting the volunteer work, they do not account for the dynamic exchange of positive resources after volunteers take up their work. Concrete recommendations for hospice organizations are provided to enhance awareness for relational exchange processes.

Introduction

Helping others has been associated with improved levels of mental health (Schwartz, Meisenhelder, Ma & Reed, 2003). Altruistic attitudes in volunteer workers were found to be significant predictors of positive affectivity, even after controlling for socio-economic status and demographic variables (Dulin & Hill, 2003). They were also linked to various well-being outcomes including maintenance of life satisfaction and overall experience of positive affect

(Kahana, Bhatta, Lovegreen & Midlarsky, 2013). Especially older adults, who experience a decreased perception of purpose in life as a result of aging, altruistic attitudes can act as protective factors for mental well-being (Greenfield & Marks, 2004), even being associated with delayed all-cause mortality (Harris & Thoresen, 2005; Brown et al., 2003). Post (2005, p. 73) concretizes this notion by stating that “a strong correlation exists between the well-being, happiness, health and longevity of people who are emotionally kind and compassionate in their charitable helping activities”. This aspect of compassion and charitable helping is reflected in the work of hospice care volunteers, a tradition stemming from the civil rights movement and a history of helping. Given these encouraging effects of volunteerism on mental health, the present study thus aims to investigate how hospice care volunteers experience mental health in relation to their personal motives and strategies for helping.

Hospice care – a history of volunteerism

The current state of hospice care in Germany has been described as “a grown mesh stemming from different roots” (Heller & Pleschberg, 2015, p. 61). Today, many different professions, organizations and civil rights movements are subsumed under this term. While early hospices were built by monks alongside routes of pilgrimage, open to anyone in need, the development of hospice was closely intertwined with Christian organizations. This stance changed with the opening of the first modern hospice in London in 1967 by Cicely Saunders, which signified a first step towards professionalization and institutionalization away from Christian dominance (Heller & Pleschberg, 2015, p. 62). Such processes of societal functional differentiation into distinct structures are what sociologist Talcott Parsons (1976, p. 43) described as indicative for social evolution; through professionalization and functional differentiation, hospice systems establish system-environment relations with their surrounding social systems. In the context of the evolving German health care system, secularization and professionalization were seen as the driving processes of such differentiation signifying paradigm change. Cicely Saunders, a medical doctor, social worker and nurse, who built the London hospice, was the first to endorse this paradigm change by proposing multi-professionalism as the supporting pillar of hospice care. According to her, taking an interprofessional perspective would be the only way to account for the complex nature of human existence with both medical and psycho-spiritual needs (Heller & Pleschberg, 2015, pp. 62-63). Following up on Saunders idea of multidimensionality, the World Health Organization (n.d.) subsequently defined palliative care as “*an approach that improves the*

quality of life of patients and their families facing the problem associated with life threatening illness, through prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”, warranting that hospice extends beyond a purely medical conception towards including the individual psycho-spiritual needs. Saunders widely used concept of “total pain” recognizes dying individuals experiences along bodily, mental, social and spiritual dimensions, calling for a bio-psychosocial-spiritual model of care, that, as a consequence, can only be properly accounted for by multi-professionalism (Gerhard, 2015, p. 16).

Hospice care was seen as the differentiated process in modern society of dealing with death and mourning. Feldmann (1997, as cited in Heller & Pleschberg, 2015, p. 65) acknowledges that this functional differentiation also led to a medicalization of dying, warranting intensive-invasive medical care at the end of life alone in disregard of psychosocial-spiritual needs proposed by Saunders. Especially in Germany, hospice care was historically conceptualized as counterpoint towards the emerging pro-euthanasia movement, a concept largely rejected by the majority of Germans due to the experience of the second world war. Discussions pertained to the topics of autonomy, dignity and welfare, but were heavily influenced by the still vivid experiences of the second world war (p. 66). Despite all calls for psychosocial-spiritual care, current directions in palliative care seem to negate the multi-professional stance proposed by Saunders: Gronemeyer (2004, as cited in Heller & Pleschberg, 2015, p. 68) concludes that current practices in palliative care advocate a primacy of the medical profession leading to increased bureaucratization and standardization of the dying process, therewith distancing itself from the volunteering roots of the movement to a medical primacy.

Hospice care has traditionally been carried out by volunteer workers (Watts, 2012). The German Hospice and Palliative Organization describes the volunteers’ core task as “approaching the terminally ill and dying persons by being there, sustaining (suffering), laughing- and crying with” the dying person (Deutscher Hospiz- und Palliativverband, 2017, p.3). The volunteers core tasks are described as first, building confidential rapport, second, psycho-spiritually assisting both the dying person and its relatives, third, supporting in the confrontation with death, fourth, supporting and overcoming difficulties of communication, and, most importantly, assisting with the resolution of social, ethical and religious questions often occurring at the end of life (p. 7). Volunteers that decide to engage in hospice care often possess skills and competences from their own biography and are expected to reflect on disease, dying and mourning in terms of their own and other experiences. Volunteers are

furthermore expected to subsume all of their actions under the dying person's needs (p. 8). Hospice volunteers possess personal motivations for meeting these demanding core tasks and measuring instruments have conceptualized them.

Assessing volunteer motivations

When it comes to identifying the underlying motivations as to why individuals decide to volunteer in a hospice, a broad variety of reasons is cited in the literature. Current scientific debates have conceptualized human altruism dialectically as either selfishly motivated pseudo-altruism or selflessly motivated true altruism (Feigin, Owens & Goodyear-Smith, 2014, p.2). It seems to be the case that this division of motives between true altruism and self-interest is reflected in the overarching structure of motivations to volunteer in hospice care (Seibold, 1987 as cited in Claxton-Oldfield, Fawcett & Wasylikiw, 2004). In the same vein, Watts (2012) differentiated between instrumental gain (e.g. gaining professional experience) from altruistic motives in hospice volunteers. While it seems that the majority of motivations in hospice care are informed by altruistic beliefs (Burns, Reid, Toncar et al., 2006) and by the fact that altruism was found to significantly predict the length of service in a hospice organization (Claxton-Oldfield, Claxton-Oldfield, Paulovic & Wasylikiw, 2012, p. 583), larger clusters of volunteer motivations were identified.

Motivational clusters were most often approached by means of quantitative inventories. This section assesses the factor structure of both the Inventory of Motivations for Hospice Care Palliative Care Volunteerism (IMHPCV) and the Volunteer Functions Inventory (VFI). While the IMHPCV is specific to volunteering in palliative care and hospice, VFI takes a broader approach with its applications mainly lying outside palliative care. Scales of both inventories were compared for thematic overlap to generate a thematic basis for the development the qualitative interview scheme.

The Inventory of Motivations for Hospice Care Palliative Care Volunteerism (IMHPCV) is a 25 item self-report measure consisting of 5 subscales, with each subscale representing distinct motives for hospice volunteerism that play a role in recruitment and retention of new volunteers (Claxton-Oldfield, Wasylikiw, Mark & Claxton-Oldfield, 2010, p.35; Claxton-Oldfield, Claxton-Oldfield, Paulovic & Wasylikiw, 2012, p. 581). Principal component analysis revealed five distinct motivational categories that represent the subscales of the inventory that accounted for 60.68% of the variance (Claxton-Oldfield, Wasylikiw, Mark & Claxton-Oldfield, 2010, p.37). In a confirmatory study with a sample of hospice

volunteers, measures of internal consistency were generally greater than $\alpha = .80$, with the exception of the leisure scale ($\alpha = .67$), thereby indicating acceptable reliability (p. 40). First, *altruism* was identified as a subscale whose items target true altruistic beliefs (e.g. “I want to help others cope with death”, “I want to make others happy and comfortable in life as well as in death”); second, the *civic responsibility* subscale covers motives pertaining to civil service (“I believe that people should give back to their community”, “It is my responsibility to help others”); third, the *self-promotion* subscales taps into motives of personal gain that are not necessarily true-altruistic (“I want to feel better about myself”, “I like the attention I get when volunteering”); fourth, the *leisure* subscale taps into the notion of spending time on activities as a hobby (“Volunteering is a hobby for me”); fifth, the *personal gain* subscale focuses also on non-necessarily true-altruistic motives related to personal gain (“I want to get a foot-in-the-door for potential employment”, “I want/need experience in a helping profession”). Multiple regression analysis revealed that “only altruistic motives were a significant predictor of length of service” (p. 583), indicating that in terms of volunteer-recruitment, true-altruistic believes “had the most influence on the decision to become a palliative care volunteer” (Claxton-Oldfield, Fawcett & Wasylkiw, 2004, p. 83), while, motivations relating to personal gain were least influential (Claxton-Oldfield, Claxton-Oldfield, Paulovic & Wasylkiw, 2012, p. 597) and were usually stronger for younger volunteers “who are looking to acquire the skills and experience they need for future employment or to supplement their resumes” (p. 584).

Another measure for categorizing volunteering motivations is the Volunteer Functions Inventory (VFI), a 30-item questionnaire that differentiates 6 separate functional motives in terms of a functionalist approach to assessment, that is based on the assumption that “people can and do perform the same actions in the service of different psychological functions” (Clary, Snyder, Ridge et. al, 1998, p. 1517). The initial version of the VFI differentiated 6 functions served by volunteerism, with alpha coefficients for internal consistency equal to or greater than $\alpha = .80$ for each scale (p. 1521). First, the *values* subscale signifies the expression of values that relate to altruistic and humanitarian motives (p. 1517), with example items being “I feel it is important to help others”, “I feel compassion for those in need”. Second, the *understanding* subscale serves the function “to permit new learning experiences and the chance to exercise knowledge, skills and abilities that might otherwise go unpracticed” (p. 1518), with items including amongst others “Volunteering lets me learn things through direct hands-on experience” and “I can explore my own strengths”. Third, the *social* subscale emphasizes motivations pertaining to relationship and connectedness with

others that “offer opportunities to be with one’s friends or to engage in activity viewed favorably by important others” (p. 1518); items include amongst others “My friends volunteer” and “Volunteering is an important activity to the people I know best”. Fourth, the *career* subscale covers career-related motives, involving preparation for new careers or the build-up of skills; items include amongst others “Volunteering can help me to get my foot in the door at a place where I would like to work” and “Volunteering experience will look good on my resume” (p. 1520). Sixth, the *protective* subscale depicts motivations pertaining to ego defense, hence “protecting the ego from negative features of the self”, thereby serving “to reduce guilt ... and to address one’s own personal problems” (p. 1518); items include amongst others “by volunteering, I feel less lonely” and “volunteering is a good escape from my own troubles”. In the final subscale, *enhancement*, volunteerism is thought to improve ego growth and development of positive emotion as a result of its connection to affect, as compared to purely protective motives”; items include amongst others “volunteering makes me feel better about myself” and “volunteering is a way to make new friends”.

In a comparison of the numbers of underlying factors in volunteerism as presented in the IMHPCV and VFI, Planalp & Trost (2009) warrant that “the existing literature thus offers conflicting evidence about the number of basic motivations of hospice volunteers” and that the IMHPCV fails to distinguish motivations from enabling conditions as a result of item wording (p. 188). In an attempt to assess how well the 6 VFI subscales fit data from volunteers, factor analysis on new data led the authors argue for a 4-factor solution instead of 6 as a result of intercorrelation: *protection* and *enhancement* also loaded strongly on *career*, whereas *understanding* was distributed across all factors (p. 190). A repeated measures ANOVA confirmed the independence of the 4 factors and ranked them according to importance from highest to lowest: values/understanding, social, enhancement/protective and career. Just as Claxton-Oldfield, Claxton-Oldfield, Paulovic & Wasylkiw (2012), Planalp & Trost found career related objectives to be associated with younger age; value-related motivates were associated with female gender and older age.

Table 1.

Classification of thematic subscales in volunteer-motivational inventories

	VFI subscales ^a	IMHPCV subscales ^b
Pseudo-altruistic motives^c	<ul style="list-style-type: none"> • Career: improving career prospects • Enhancement: development and growth of the ego • Protective motives: protecting the ego • Understanding: gaining knowledge, skills and abilities 	<ul style="list-style-type: none"> • Personal gain • Self-promotion • Leisure
True-altruistic motives^c	<ul style="list-style-type: none"> • Values: expressing personal, altruistic and humanitarian values • Social: developing social relations 	<ul style="list-style-type: none"> • Civic responsibility • Altruism

^a Clary, Snyder, Ridge, Copeland, et al., 1998, p. 1520

^b Stelzer, Lang, Hörl, Kamin & Claxton-Oldfield, 2018, p. 311

^c Own categorization based on literature review.

Hospice volunteering so remains a complex undertaking for volunteers, who, possessing a diversity of personal motivations, face a highly demanding task. Theories on positive mental health formulated how individuals can come to positive functioning despite facing demands of life.

Defining mental health

In popular discourse, the term mental health is inevitably associated with psychopathology, disease and malfunctioning of the psyche. In contrast does WHO defines mental health as a decidedly positive conception, where mental health is “a state of *well-being* in which the individual realizes his or her own abilities, copes with the normal stresses of life, works productively and fruitfully and makes a contribution to his or her community” (WHO, 2018). Current clinical practice seems to contrast this notion, as Maddux (2009) warrants the fact that the psychological profession remains fixated on an ingrained rationale of “illness ideology”, largely lacking the recognition of positive functioning in the practical definition of mental health. Until today, components of mental well-being have, in fact, not been systematically integrated into clinical practice (Bohlmeijer & Westerhof, 2019, p.4), as still the tacit assumption prevails that mental illness and health represent single bipolar dimensions. Proponents of positive psychology in contrast postulated that those phenomena would be best represented as “separate, correlated unipolar dimensions” (Keyes, 2005, p. 539). Mental health in this vein is characterized by hedonia and positive functioning (Keyes, 2005, p. 540; 2002, p. 208), whose facets include the domains of both *psychological well-being* and *social wellbeing*.

First, *psychological well-being* is a notion characterized by Ryff’s (1989, p. 1072) six theory-guided dimensions of well-being that include *self-acceptance*, *having positive relations with others*, *personal growth*, *purpose in life*, *environmental mastery* and *autonomy*.

Positive relations with others are operationalized as being capable of showing empathy, affection and intimacy in their personal relationships with others, resulting in a general tendency of building trustful connections to others, in which concern and care for them comes seamlessly and without force.

Purpose in life involves that individuals perceive a sense of meaning in current life and the past, resulting in the belief that life itself is a purposeful undertaking. These individuals possess stringent goals for their life and have an optimistic outlook for their realization.

Environmental mastery is the idea of exhibiting competence in managing a diversity of external activities. Individual have a complex and effective understanding of their external contexts, and feel able “to choose or create contexts suitable to personal needs and values” (Ryff, 1989, p. 1072).

Self-acceptance relates to the idea that individuals hold a positive attitude towards themselves, while at the same time recognizing the self as a multi-faceted agent in possession

of both good and bad qualities at the same time. The individual does not wish to change fundamentally as compared to what he is momentarily, leading to an overall positive evaluation of their previous life.

Personal growth describes that individuals perceive themselves as constantly developing themselves in terms of own potentials and behaviors by exhibiting openness to experience and showing positive regard for personal developmental achievements.

Autonomy underlines the role of self-determination in individuals that experience well-being. Highly autonomous individuals feel able to act regardless of foreign expectations, feel able to bring about decisions in life from their own convictions, and engage in self-regulation according to a set of personal standards independent of external influence.

As a second factor in the conceptualization of full mental well-being, the dimension of *social well-being* includes the concepts *social acceptance, social actualization, social contribution, social coherence and social integration* (Keyes, 2002, p. 209). Individuals experience social well-being when they feel accepted by others, can perceive society as a place for evolving self-actualization in which they can provide meaningful contribution, and the experience of feelings of belonging. As such, “the dimensions of social well-being ... are indicative of an individual’s mental health” (Keyes, 2002, p. 209).

Research question

While all these quantitative inventories were able to provide the motivational factor structure of volunteers, the question as to how this diversity of motives is linked to states of mental health remains open. As to today, no research on how hospice volunteers *themselves* experience the link between their motivations and their experience of mental health has been conducted, yet such understanding would be necessary to make recommendations for improving recruitment, retention and mental health of volunteers. This study aims to fill this gap by gaining qualitative insight into this phenomenon within a grounded theory framework.

- How is the idiosyncratic experience of mental health in hospice care volunteers related to their motives and strategies for volunteering?

Methodology

Design and reflexivity

Ethical approval was obtained by the ethical committee of the Faculty of Behavioral, Management and Social Sciences (BMS) at the University of Twente under nr. 201074.

A qualitative, constructivist grounded theory approach was taken using a theory-based semi-structured interview schedule in lieu of Bowen's (2006) sensitizing concepts approach to grounded theory. This was done to regard the existing literature on hospice volunteer motivations and second, in response to feasibility concerns stemming from the limitations of time given in a master's thesis that could not adequately encompass full conceptual openness of unstructured interviews and, third, to provide transparency about the concepts that were previously known to the researcher. Current theories on human altruism divide motives into either true-altruistic or selfish-motivated pseudo altruism. The interview schedule was therefore structured to differentiate altruistic and pseudo-altruistic motives (Feigin, Owens & Goodyear-Smith 2014, p.2). Items were thematically derived from the factor structure of both the Inventory of Motivations for Hospice Palliative Care Volunteerism-German version (IMHPCV, cf. Stelzer, Lang, Hörl, Kamin & Claxton-Oldfield, 2018) and the Volunteer Functions Inventory VFI (Clary, Snyder, Ridge, Copeland, et al., 1998). In addition to these sensitized concepts, participants were given space in the interview schedule to talk about their own concepts

Special attention was paid to issues of reflexivity, since in grounded theory, "we don't separate who we are as persons from the research and analysis that we do. Therefore, we must be self-reflective about how we influence the research process and, in turn, how it influences us" (Corbin & Strauss, 2015, p. 27). Caution is warranted by the fact that both the researcher himself and the subjects of the study belong to the same professional group of hospice volunteers, working co-operatively in the same organization. Such *insider research* is defined as "conducting research with populations of which they are also members so that the researcher shares an identity, language and experimental base with the study participants" (Kanuha, 2000 and Asselin, 2003 as cited in Dwyer & Buckle, 2009, p. 58). Such constellations can result in role confusion that influences interaction and disclosure behavior (Raheim, Magnussen, Sekse, et. al, 2016, p. 5; Dwyer & Buckle, 2009, p. 58). Subjects may perceive the interview as a test of their professional knowledge, interpret the interview as an

evaluative “pass or fail” situation that scrutinizes their professional identity and, as a result, provide answers that are socially desirable in accordance with their self-perception of professional identity (Coar & Sim, 2006, pp. 254-256; Raheim, Magnussen, Sekse, et. al, p. 7). Positive aspects of peer-to-peer interviews are the possibility of gathering richer data due to the researcher having prior knowledge about the professional culture and terminology allowing for richer interpretation of meaning (p. 255). Such constellations can evoke feelings of intra-professional solidarity that enhance the willingness to disclose. On the contrary, the challenge to the traditional conception of researcher-researched relationship can negatively affect data collection: researcher and subject are not anonymous entities that will never meet again as in usual research situations, but colleagues of comparable social status with a high likelihood for future cooperation within the same organization, leading the subjects to consider as to whether sharing sensitive personal information can impact their future perception as professionals. Dwyer & Buckle (2009, p. 58) also warn that subjects may hold “assumptions of similarity” towards the researcher that result in failure to disclose their experience in its entirety: through assuming that the researcher ‘already knows’ parts of their inside perspective, providing a full account can seem pointless to the subject.

To solve this dilemma, Burns, Fenwick, Schmied & Sheehan (2012, p. 59) have argued for “occupying a space in the middle” between insider-outsider positionality during the interview that allows researchers to make optimal use of their pre-existing insider knowledge at the same time maintaining distance and detached reason. Feminist researchers have implemented such middle space by use of a participatory model that highlights a non-hierarchical, non-manipulative researcher-researched relationship in which researchers “bring their personal role into the research relationship by answering participants questions, sharing knowledge and experience, and giving support when asked” (Oakley, 1981, as cited in Dwyer & Buckle, 2009).

During this study, the middle-space was realized by open disclosure of the researcher’s status as a hospice volunteer himself. Although having shared the same training in hospice care as the participants, some of the participants have been in hospice service for more years than the researcher, implying a broader experience. To prevent the pitfall of “assumption of similarity”, subjects were continuously asked to provide more descriptive detail in situations where they referred to concepts from the shared base of experience between researcher and subject or when the researcher felt that they were addressing him in his collegial role as a fellow volunteer. Openly accepting the dual role of researcher and peer sought to foster intra-professional solidarity. Asking questions in the tone of a “shared

identity and language” served to generate more detailed descriptions by the reduction of hierarchy, as was proposed by Oakley (1981). Furthermore, the researcher stated that the interview situation was no assessment of professional competency, to prevent subjects from feeling threatened in their role as professional peers.

Interview and materials

The semi-structured interview questionnaire was divided into four parts. The first part covered initial open questions to build rapport and to obtain general socio-demographic information. The second part tapped on pseudo-altruistic motivations from IMHPCV and VFI. The third part assessed altruistic motivations. Lastly, part four represented an open space where participants could talk freely about their experience and anything that might have come to mind during the interview. This part was also used for theoretical sampling, following up on concepts of previous participants and to saturate their ideas more. While Corbin & Strauss (2015, pp. 38-39) have advised against the use of interview schemes in grounded theory, semi-structured interviews can be feasible if “after the questions ... have been covered, participants are free to add anything else to the interview that they might feel is relevant to the discussion”. Part four realizes this recommendation.

During the initial few interviews, it was adhered somewhat strictly to the scheme; in subsequent interviews however, more importance was assigned to the emerging concepts from theoretical sampling in part four. Following each interview, additional questions for further theoretical sampling were developed based on the data of the interview at hand. Participants were given the freedom to express any additional concepts or ideas that were not thematically covered by the interview. This combination of semi-structured questions combined with theoretical sampling and open space for input strive to account for Charmaz (2006, p. 29), who located optimal interviewing in grounded theory as “a combination of flexibility and control”.

Participants

The study was conducted in 2020 and focused on adult non-professional hospice care volunteers that provide end-of-life counselling in a local hospice care organization in western Germany.

Inclusion criteria were the successful completion of at least one formal training course in hospice- or palliative care volunteering, minimum membership time in the hospice organization of ≥ 1 year and having completed at least one case of palliative counselling involving direct contact with a dying client. Exclusion criteria were insufficient formal training, cognitive or physical ability. However, no participants had to be excluded on the grounds of these criteria.

A total sample of 7 woman with an overall mean age of 56 years (SD = 14.5), ranging from age 24 to 56 was obtained by convenience sampling. All participants were previously known to the researcher. Mean interview length was 51.8 minutes, ranging from 31 to 95 minutes.

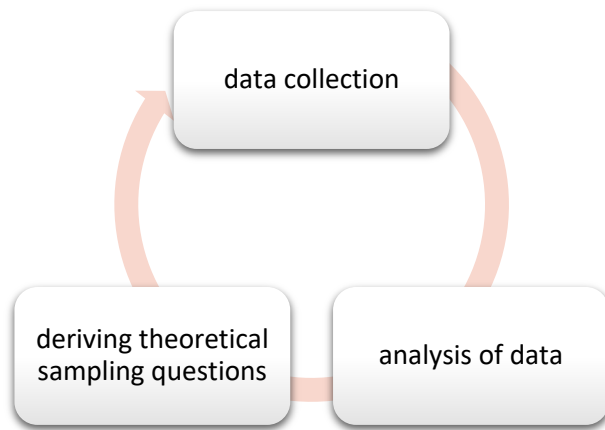
Data collection

Participants were obtained by an invitation email sent to all active volunteers of the organization through the administrative board. Interviews were then conducted both in the organizations building and in the volunteers private homes.

In grounded theory, data collection and analysis are a circular process informed by the notion of *theoretical sampling*, a method of data collection where emergent data is collected to saturate the concepts of previous participants in their properties and dimensions to “uncover variations and identify relationships between concepts” (Corbin & Strauss, 2015, p. 134). Data was collected by a pragmatic approach in which the first case was chosen by convenience. Structured questions from the first part of the interview scheme served as sensitizing starting points to start the conversation. After each interview, theoretical sampling questions were derived from the concepts brought about by the participants to guide further data collection and to saturate the emerging concepts in terms of their properties and dimensions. In this way, interviewing and analysis of data became an intertwined process, in which concepts of the participants acted as linking agents between the cases.

Figure 1.

Interrelation between data collection, analysis and theoretical sampling



Data analysis

All interviews were manually transcribed using F5 audio-transcription software. All personal data, including names and locations, was omitted from the transcript. Analysis was conducted on the original, non-translated interview data in German, with reported quotes being translated by the author. Coding was done using MAXQDA 20. Subsequently, data was analyzed following a grounded-theory paradigm (Corbin & Strauss, 2015; Charmaz, 2006) from a constructivist perspective.

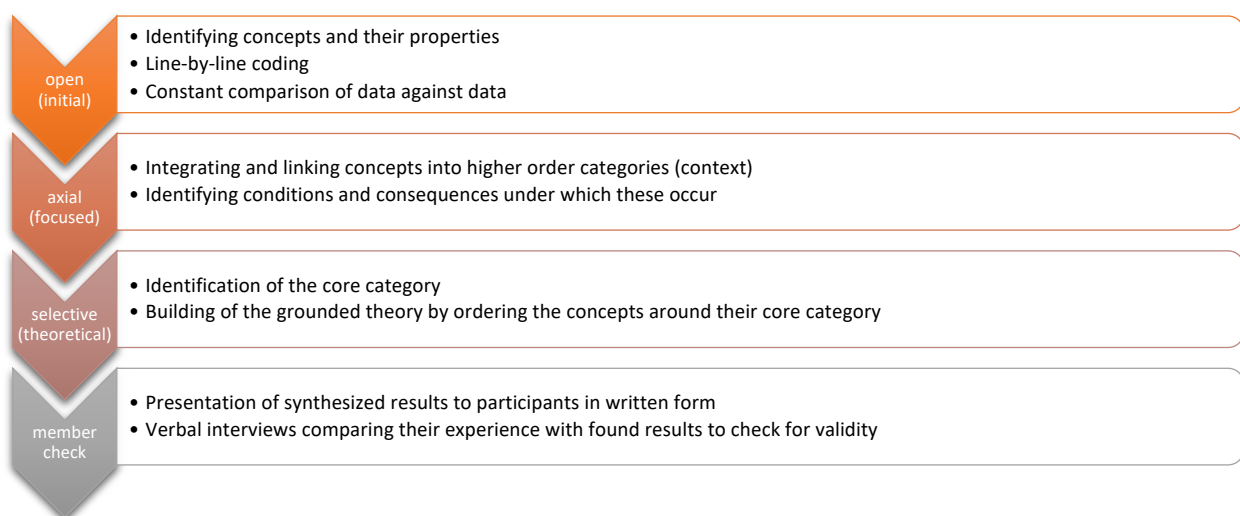
First, during initial coding (open coding), concepts and their properties and dimensions were identified inductively through line-by-line coding of the material. Empirical codes were formulated using a few short descriptive action words and then subsumed in coding tables (cf. appendix A). Then, empirical codes that referred to a similar concept were grouped together to form substantive codes, with the former empirical codes denoting the substantive's code properties and dimensions (Stegmaier, 2020). Thereby, merging empirical codes brought about the substantive codes. Codes were compared with each other across documents in order to search for conceptual differences and similarities (Corbin & Strauss, 2015, p. 94), and differences indicate of gaps in the data were used to direct the development of further theoretical sampling questions.

Second, during focused (axial) coding (Charmaz, 2006, p. 57), the most significant

and frequent codes were selected and integrated into higher order categories through constantly comparing them with each other across interviews. Each higher-order category from focused (axial) coding was then described separately in the results section, forming the skeleton of the grounded theory; categories 1 to 9 represent these higher order categories.

Third, during theoretical (selective) coding a core category was identified by selecting the one concept that was present in every interview, was broad and abstract and descriptive of the study’s main idea (Corbin & Strauss, 2015, p. 187). All other higher order categories were clustered around the core category. The relationships between each higher order category and the core category were established by writing a descriptive summary memo (Corbin & Strauss, 2015, pp. 191-192) that synthesizes the main ideas down to a descriptive synopsis setting all concepts in context.

Figure 2.
The research process



Member check

Validity of results is verified by a synthesized member checking approach after the production of results concludes (Birt, Scott, Cavers, Campbell & Walter, 2016, p. 1). Member checking enhances the trustworthiness of the results by allowing participants to engage with the findings, allowing them to compare their experience with the theoretical model, and, if necessary, to add new meanings or to voice disconfirming opinions.

The synthesized member check was executed in a face to face setting with three former participants in which they received synthesized summary of the categories along with

illustrating quotes in a non-scientific language. Such verbal member checking interviews are coherent with the researchers position of constructivism, in that it accounts for the co-constructed nature of knowledge production by empowering the participant to introduce personal experience into the verification process (Birt, Scott, Cavers, Campbell & Walter, 2016, p. 4). Participants are asked whether the result synthesis matches their experience and whether they would like to change or add anything. Participants are asked to write down all responses onto a separate worksheet. Results of the member check are then presented in the light of the models' categories with the aim of integrating any new findings and to test disconfirming information (cf. Birt, Scott, Cavers, Campbell & Walter, 2016, p. 5).

Results

How hospice care volunteers come to idiosyncratically experience mental health in relation to their motives and strategies is synthesized in the descriptive summary memo that provides an integrative overview of the categories. Following, all higher order categories are described in more detail.

Descriptive Summary Memo

Purpose of the descriptive summary memo is to integrate the found categories around a selected core category, representing the grounded theory as a coherent picture and in a descriptive tone. The descriptive summary is visually represented in figure 3. Mental health in hospice volunteers stems from the mutual exchange of resources in the enacted relationships between the involved actors: the client, the organization, the volunteer, the overall cohort of volunteers. While each actor exchanges a qualitatively different set of resources, the exchange of appreciation is a process that all actors share; therefore, it was chosen as the core category.

As a first contextual condition, hospice volunteering involves a *learning journey* for all involved actors at both the intra- and transpersonal level. Volunteers become sensitized to the thematic complex of death and dying through active learning efforts, e.g. their participation in preparatory courses. Since death in society is still a taboo, sensitivity cannot be taken for granted but needs to be developed actively. During this process, volunteers develop practical skills for dealing with uncertainty and endurance. With developing sensitivity, volunteers recognize that hospice work extends beyond the dying individuals to themselves but also towards their family systems. Lastly, volunteers develop a coherent

personal position towards their own finiteness in life, allowing them to appreciate their own life and health more.

As a second contextual condition, hospice volunteering always operates within the societal *culture of dying*. Dying is embedded in both cultural and institutional practices, in which volunteers are both agents and impacted recipients themselves. Cultural norms dictate as to whether death is perceived as public or secretive private event. Culture has become more open to new and personalized forms and practices around death, stripping away the inherent secrecy in death. At the same time, institutional practices have changed with palliative medicine's increasing focus on pain and anxiety reduction – again resulting in a higher visibility of death. In the medical model, time is a lacking resource for dying individuals, and volunteers in turn can feel motivated to resolve this issue by donating their time. Despite all the advances, stigma around death and hospice still prevails, forcing volunteers to adopt strong communication skills to convey the idea of hospice to clients and their families in an effort to resolve stigma.

The volunteer itself lies at the core of the model. Volunteers can hold personal interest about death as a result of previous life experiences and may start volunteering to satisfy their interest. Voluntary work is perceived different than paid labor, as volunteers receive *appreciation from clients* instead of money and organizations as the currency of interaction. Volunteers can hold the motivating desire to act as *patient-centered psycho-spiritual helpers* for clients and their social systems. Volunteers often recognized the notion of having a helper's syndrome, exerting the willingness to help and make the world a better place by their actions. However, some helpers recognize the maliciousness of this idea calling for a stricter selectivity of helping by recognizing the sphere of responsibility for volunteers. Others have called for developing a professional identity, that is selectively activated in contact with clients, helping to keep private and professional identities apart. As further strategies, volunteers often import professional knowledge from their regular paid jobs, that often lie in the social realm. Volunteers develop clear conceptualizations of their *boundaries and use emotional awareness* to enforce them. Others rationalize the contact with clients, allowing them stay on the factual level. Recognizing that doing nothing and to just endure in contact with clients was also mentioned. Last, helpers use *situated flexibility* to respond to the rapidly changing desires of dying clients; this recognizes that a fixed skillset is not always optimal.

Altruistic motivations were present in all volunteers, however having them did not exclude holding pseudo-altruistic motives at the same time. Prominently, volunteers described the conviction that they were acting out of an inborn predisposition towards helping outside

of egoistical motives. They furthermore expressed the desire of giving something back to society or the desire to be a morally good person. Such altruistic motives are both intrinsically and extrinsically rewarding: as helpers perceive a sense of achievement and self-efficacy, intrinsic motivation extends; at the same time, *clients and the organization express appreciation* for their actions, serving as extrinsic motivation. When the own volunteering is seen as a meaningful activity, volunteers gain positive affect from knowing that their work is meaningful to others, that, again, often express their appreciation for their meaningful work.

Pseudo-altruistic motivations often were a means of preparatory self-interest behavior. Some volunteers hoped to obtain structural knowledge about local medical structures from their work, hoping to use it for their own death or the care of relatives. Other volunteers had the desire to *realize personal values in an organizational context* through shaping their policies. The willingness to work at an administrative organizational level was often appreciated from fellow volunteers. Lastly, volunteers set and enforce *personal boundaries* (“healthy egoism”) to prevent becoming too interwoven with family dynamics or to emotional overload. While healthy egoism does not represent immediate benefit to the volunteer, it was classified as pseudo-altruistic since its aim is to protect and enhance the ego.

The client-volunteer relationship had the dual goal of reducing stigma still pertaining to the term hospice, while, at the same time, to sustain a *patient-centered congruent relationship*. Volunteers used divulging, i.e. the release of personal information into the counselling relationship, so that volunteers were recognized as congruent and accessible entities. As described above, selective helping, again, presented itself the client-volunteer relationship. As the major outcome of a healthy client-volunteer relationships, volunteers experienced self-efficacy by feeling needed and actually seeing their actions as turning out beneficial for the client. Clients often expressed *appreciation* for the volunteer’s efforts, which often heightened their perception of self-efficacy.

The organization has a trifold role. First, the organization *provides interpersonal back-up resources* in the form of consultations with the management board, by external supervision and through setting up activities with the group cohort. Volunteers *appreciate the fact that they can always rely on this interpersonal back-up*, make use of it as a strategy and also appreciate the *learning opportunities* that the organization provides through their courses. Volunteers perceive hospice volunteering as a team activity and use the group meetings for *collective decision making* and *mutual normalization of experience*. Note that *group events are coordinated by the organization*, therefore being a resource provided. In return, the *organization provides the volunteer with appreciation* for doing this difficult work and

donating their free time. Second, the organization seeks to foster the institutionalization and professionalization of hospice work through obtaining third-party finance from insurers and by moving away from the movements Christian roots through *providing learning opportunities for professional knowledge*. Third, the organization acts as a *regulatory body* in aiming to protect clients from intrusive volunteer behavior by weeding out volunteers that seek hospice education purely for feeling better themselves. Fourth, the organization provides clients with procedural information about the upcoming work with the volunteer, involving setting up contracts.

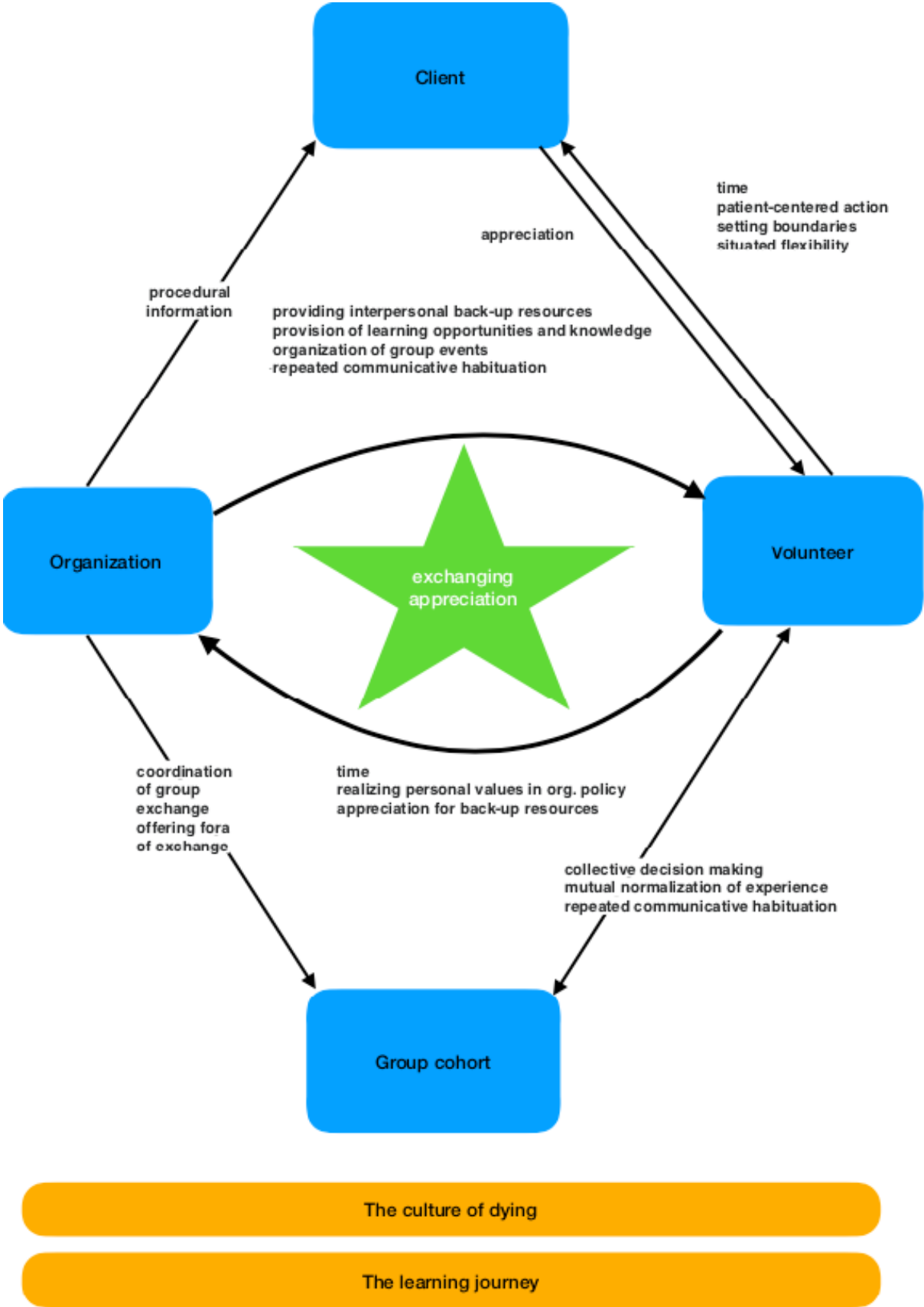
Mental health in volunteers is thus a function of resource exchange between all involved actors. As a main benefit to mental health, fear reduction is achieved by both pseudo-altruistic and altruistic strategies.

First, fear reduction by obtaining structural knowledge is a pseudo-altruistic strategy, in which the obtained knowledge about local medical infrastructure reduces uncertainty and concerns about the own death. Having structural knowledge equates to already having experienced these structures, which reduces anxiety.

Second, fear is reduced by *repeated communicative habituation*. During their education as hospice volunteers, the helpers engage in prolonged communication about the topic with the group cohort and the organization itself, inviting to perceive death as a natural part of life that does not need to be feared. The repeated processing and thinking about own finiteness allow the volunteer to accept that life is finite.

Third, fear is reduced through the *exchange of appreciation*. Clients appreciate the volunteers for spending their time with them, relatives appreciate the volunteers for providing them with a much-needed break from care, and the organization appreciates the volunteer for his work. The volunteers themselves appreciate the learning opportunities provided by the organization and also appreciate that clients and their families allow them to enter their social system. This appreciation results in an increased sense of self-esteem, acceptance of death and overall positive affect.

Figure 3.
Hospice volunteering as exchange of resources



Category 1 – The learning journey

While the descriptive summary memo provided a global overview over the theory and its categories, the constituting elements, i.e. the used categories, remain to be described in detail; the following descriptions saturate the overview and provide participant quotes to illustrate the concepts.

Becoming a palliative care volunteer is a multi-faceted learning process at both the intra- and transpersonal dimension, both within and outside of the volunteer. The productive coping within these processes results in perceived gratitude at the side of the volunteer, who made the active decision to embark on a personal learning journey prior to taking up the volunteer work.

At the intrapersonal dimension, the learning process starts by becoming sensitized to the thematic complex of dying, death and mourning. This sensitivity is not a common occurrence, but an understanding, that is often collectively learned in other professional contexts of the volunteer, e.g. the workplace: “I really got carefully introduced so that I wouldn’t fear death, as a young girl ... and in this case, it was at the hospital ward where they took me by the hand and said: look, this is what death is like!” (Eva). As the thematic complex of dying is not a common spoken about subject in society, volunteers may feel overwhelmed and helpless, and especially so when introduced to clients that experience difficulties at the end of life. Ridden between the desire to help and the sobering reality that living up to this ideal cannot always be possible, volunteers realize that there is “a certain borderline” where “you cannot make everything as beautiful as one might wish” (Eva). Witnessing such excruciating deaths can cause negative affect as the dissonance between the volunteers ideal and reality can often not be bridged: “and when I see how long a human being has to torture himself until he can finally let go, I feel immensely sorry”. Situations where such dissonances are present involve feelings of uncertainty, either because volunteers’ question whether their actions are indeed beneficial for the dying individual or because there is a lack of feedback from the client, who are often unable to communicate verbally: “and I sat there and didn’t get any reaction. I tried to caress her but didn’t know if it felt good to her” (Barbara); “I was responsible for applying morphine patches, and I wasn’t sure whether I noted down the right time of application. I was so unsure that I applied the morphine again, and she entered such a deep sedation that I thought: you killed her!” (Lynn). Developing a tolerance for uncertainty thus lies at the heart of the intrapersonal learning journey, and volunteers describe that learning to just endure uncertain situation was something that came

not naturally at first: “simply sitting there and endure these situations is a very, very tiring thing and I perceived this to be very straining” (Barbara); I read her stories, but it didn’t bring about any reaction ... for five days, just sitting there, occasionally taking her hand, was hard. It was difficult.” (Barbara). Developing strategies to deal with endurance situations was common: volunteers either try to develop other (often tactile) means of communication when verbliness becomes impossible or they re-iterate narratives from experienced hospice volunteers that often cite that sometimes just enduring is enough: “besides, you can do a whole lot of other things; by careful touching, massaging their hand; others like it if you comb their hair!” (Sarah); “we learned that it is all right if you do nothing and just sit there ... we learned this in the course and I re-iterated it in my memory” (Barbara). At the same time, the volunteers are confronted with their own mortality, both by the practical interaction with clients and by the theoretical learning in the preparatory course at the hospice organization: “I sat at the bedside of the dying person and thought: hopefully, if I were to be in this situation, somebody would be there as well.”; “we did a seminar ... and were asked to imagine that if we were to die, how would we want it?” (Eva). By developing concrete thoughts about one’s own finiteness during the learning journey, most volunteers develop an accepting stance towards death: “and when you eventually start to think about your own finiteness, the topic is not as big anymore but gets the place assigned it ought to have” (Sarah); “that one takes the necessary time and abstains from trying to forcibly change things so that one can accept death” (Eva).

At the inter-personal dimension, hospice volunteers learn to perceive end-of-life care as action-interaction beyond the dying individual himself. Often, relatives of the dying individual become involved in their actions, either because they feel plagued by feelings of guilt or voice concern about communicative barriers towards the dying person: “many relatives share thoughts along the lines of: what if I stayed? What if I hadn’t brought him to the care home? Why did I stop caring? Why did we argue yesterday? There are lot of questions of guilt that happen to occur then” (Eva); “bringing people together who cannot speak with each other. Nothing is worse than, at the end of one’s life, not being able to look your wife into your eyes because both now that something is left unspoken between them.” (Sarah). By dealing with such incidents, volunteers learn to incorporate inter-personal relationships into their focus of work.

Outcomes of the learning journey are thus first, the development of practical skills that help deal with uncertainty, endurance situations and communicative barriers and. second, to form a personal position about one’s own finiteness of life. If these learning outcomes are

achieved by the volunteer, it is likely accompanied by feelings of gratitude: “I am thankful that I was allowed to be there, that the family allowed me to do this work, ... that they trusted me and let me enter their home” (Sarah); “you experience your live completely differently through it! ... you enjoy your life more, you are thankful about your health ... overall it was an all positive experience!” (Eva).

Category 2 – The culture of dying

Dying is accompanied by and embedded in both cultural and institutional practices. The culture of dying is a broad term, aiming to signify that volunteers do not act separated from these contextual factors, but rather are active agents in cultural processes themselves. Volunteers as cultural agents actively reflect on cultural-institutional norms, stigmata and practices so that making the decision to volunteer is often motivated by the recognition of cultural shortcomings in how dying individuals are treated.

First, the extent to which death is considered a private or public event is shaped by cultural norms. Practices of mourning differ in their degree of publicness, valence and personalization. Many participants explained that the overall culture of dying has become more open, in that dying itself has become a highly personalized act characterized by a wider choice of options: “it became more open because today, you can engage non-religious speakers ... there are different kinds of graveyards, you can have funerals at sea, and all this things did not exist back then ... people realize that they can take more time for saying goodbye to their deceased relatives, you don’t have to empty everything and rush it through anymore” (Lynn).; “during the funeral, we placed many different funny t-shirts in the chapel ... we’ve made it a funny funeral” (Eva). Besides a wider array of individual choices, institutional norms concerning the handling of dying patients changed: while it was common to “separate all dying people away from the living ones, away from the entire scene” and even to “lock them into a chamber besides the escalator, where they could vegetate for themselves and die” (Eva), today, institutions account for this difficult process by curating designated and peaceful rooms for dying, where it is encouraged to invite relatives and friends so that death is not as private and silent as used to be. At the same time, advances in palliative medicine have changed the public opinion on the role of pain during the process: modern analgesics set a focus on pain and anxiety reduction, weakening the idea that death is necessarily an extremely painful process: “as a result of palliative care, it is a bit more relaxed

so that you can free the dying persons in their final phase from anxiety (by) giving them injections faster. It is not relevant anymore whether someone dies a day earlier by this practice.”(Eva). Whether death is considered a private event pushed away from live or whether death is considered a part of life can thus be reflected in how institutions handle the dying process: “the dying person is not left alone in the hospital. There is someone sitting with him from the personnel. Back then it was not the case, and it is positive that our society has become closer to the dying individuals” (Barbara). However, death was not always considered a private event; in the rural regions of the federal state, volunteers recount dying as an event the whole family participated in: “in our rural agricultural community, it was custom to do a night watch ... it is good if the family members have the time for it so that the dying person knows she’s not alone!” (Barbara). At the same time, cultural norms dictate how the mourning individual is ought to express their grievance: “earlier, as a widow, you were supposed to wear mourning-clothes for a year. Thank god that this is not the case anymore today ... if I feel to visit the club after four weeks: alright, I’ll do it!” (Eva). While surely most of these changes were perceived positive, volunteers described that societal norms still exclude and actively prohibit some forms of death, most prominently euthanasia: “and I regret that in our society, euthanasia is still a taboo ... I worked with three clients to the end ... how a human has to suffer, knowing that he won’t improve! ... Still, death did not come for until a week and that was negative” (Barbara).

Second, palliative care and hospice work are resource-intensive processes that draws on societal resources, i.e. the possession of sufficient time to provide an appropriate level of care. Especially in view of the increasing institutionalization of palliative care, volunteers must often realize that professional medicine is lacking the resource of time to live up to its promise: “we increasingly had less time available for these persons. Sometimes we were just putting on socks in the morning, gave them medicine and came back in the evening, put off their socks. In the meantime, they were sitting in their chair for eight, ten hours on end, alone” (Kate); “and I realized that a lot of time was lacking for the palliative clients and I could not fully account for them on their last journey so that they could leave with dignity!” (Eva). Taking up hospice volunteering can thus be understood as a response to the lacking timely resources within the medical system: “I increasingly got the wish to allocate more time to the dying ... it is a certain luxury to gift someone the time he needs ... frankly the factor time is my biggest motivation” (Eva).

Third, hospice is still an unknown, and partially stigmatized term in society: “for many, hospice is still a red flag ... when they heard the term hospice, they shut down” (Kate).

As such, lacking knowledge as to what hospice organizations do is common. This uncertainty causes clients and their relatives to speculate, bringing up expectancies towards the volunteer: “people do not know what a hospice exactly does. And they have certain expectations towards you. If you enter their premises and to not feel at ease, it is difficult because you have to lead the conversation” (Kate). Confronted with the expectation to firmly guide the conversation, volunteers develop communicative skills that help to make contact with their clients and to structure their conversations. It is by the repeated exposure to such communicative situations that volunteers perceive their work a learning opportunity. When volunteers are repeatedly able to prove themselves successfully in such communicative situations, increasing self-confidence develops as an impact on mental health: “and I got to realize within the walks of years that I grew a certain body of experience that benefitted my self-esteem” (Kate).

Category 3 – The volunteer

Volunteers are the executing agents who commits to their work within the surrounding context of culture and learning. This section focuses on how volunteers come to build their professional role-identity and what strategies they see part of that identity.

The process to formation of professional identity as hospice volunteer usually starts early in life, with personal interest developing through inquisitiveness and a general interest in life stories: “since my childhood days, I liked to visit graveyards. I also liked to think about older persons, and I always felt that I had good rapport with them” (Leora). Volunteers experience their work differently than they do in paid labor, and how they perceive clients appreciation is informed by the fact that their work was voluntary: “I perceive it completely different – it’s no job but a piece of personality that I give to the people, no work, no chore” (Leora); “appreciation is the only wage you get as a volunteer. I’m doing this voluntarily to effect something. And if I can realize that its effecting something, I’m feeling well. It’s the only kind of appreciation that I get for the work I’m doing – we’re not getting paid” (Sahra). Yet, hospice volunteering is perceived as a dialectic activity, that can both be a burden but at the same time be perceived as a personal enrichment: “I did the basic course but when time came to continue training, I changed my mind, it would have been too much for me” (Barbara); “my plan is to spend more time in hospice because I really enjoy it and because I myself are feeling well there as well” (Lynn). At the core of the volunteer’s professional identity lies the self-perception as being a psycho-spiritual helper, that provides clients with psycho-spiritual care often lacking in the medical model. Such psycho-spiritual care involves

answering fundamental questions and to build communicative bridges between clients and their relatives, so that honest communication about the illness at hand becomes possible again: “bringing people together who cannot speak with each other. Nothing is worse than, at the end of one’s life, not being able to look your wife into your eyes because both know that something is left unspoken between them. Guiding conversations so that people can speak again with each other is one of the biggest challenges”; “often, there is a huge speechlessness between the sick person and their relatives. ... I’ve been called by a palliative doctor about a dying client, who, sitting in his bed told me: ‘I know that I won’t survive this, but don’t tell my wife, she couldn’t cope’ ... then I spoke with the wife ... she said: ‘I know he’s not going to make it, he’ll die. But he doesn’t know. He couldn’t cope’” (Sahra). Building such communicative bridges requires the ability to understand hospice volunteerism as extending beyond the clients to their larger social network, thereby encompassing multiple stakeholders perspectives: “the relatives need a lot of solace but also ... had a lot of question concerning care, also in view of the funeral ... and I was able to talk to them and realized that the need for such conversations is even bigger with the relatives than with the dying person themselves” (Kate). Another often cited characteristic of hospice volunteers was the possession of a helper’s syndrome. Many volunteers acknowledged having a such syndrome themselves, characterized by a high willingness to help others and to make the world a better place by their actions: “I think I do have a helpers syndrome ... almost everyone working here has it, and being able to help is personally important to me” (Barbara); “having it is the most natural thing in the world, I’m not thing about it. If someone is in need of help, I simply do it without thinking much about it” (Lynn). While having a helper’s syndrome can certainly be a strong motivation, it was likewise identified as a malicious factor, imposing the danger of intrusiveness to the client – the volunteer is not helping anymore for the sake of it, but to feel good about him*herself or to veil own problems: “people with helper’s syndrome are intrusive! They act to serve their own needs. They’re not helping for the sake of helping ... but they help to feel good. ... I do not feel entitled to save the dying client or to save the world ... I refuse to be intrusive” (Sahra). According to this participant, the development of professional identity pertains to recognizing intrusiveness by becoming more selective as to what actions can be executed without becoming intrusive: “I do not start providing care work. I do not start living in their household. These are all intrusive things. I do not meet with them privately. I end the contact when the client has died. I ask them what I can do, where I can help but also tell them honestly what I can and can’t do.” (Sahra). Overall, individual participants went as far as to describe the professional volunteer’s role as a “costume” that

they put on when working with clients but push it away when leaving. In this sense, professionalism can mean the development of an identity apart from everyday life that is selectively activated.

Volunteers make use of different strategies that inform their professional role and mental health. Many volunteers stated that they hold jobs in care work, and as a result of these, are able to import professional knowledge into their volunteer practice: “I’ve been working in care and because of that, I knew a lot about the bureaucracy, I know where they can get help” (Kate); “I’m a nurse ... I’ve always been guiding dying people.” (Sahra). Another strategy is the volunteer’s emotional awareness: through their training, volunteers form a clear conceptualization of their emotional boundaries and defend those by exerting professional distance to the clients experience: “It was always clear for me that I wouldn’t want to work with kids or women in my phase of life or at the same age ... that’s why I made it clear for me which groups I’d like to counsel” (Leora). Another strategy applied by some volunteers is mindfulness: through the repeated exposure to death, volunteers report becoming more mindful towards themselves: “I believe that through the constant processing with these topics, I started living more consciously and to enjoy the moment more ... I believe I got more conscious, and also gentler” (Sarah). Being mindful, but more prominently so developing resilience and self-care were prominent topics for most volunteers: “I am proud that I am having a fair share of resilience ... one thing is psychohygiene, that you do not let things come close to you. If you do not have mental strategies, you’re not resilient. But I always had these strategies” (Anne). While mindfulness pertains to the intra psychological factors of the volunteer, rationalizing is another strategy more focused on the outside facts. By trying to adopt a factual outlook, volunteers form a realistic picture without giving in to over-dramatization or understatement. Such realistic outlooks prevent the volunteers from becoming hijacked by situations with clients: “when you perceive things on the factual level, you’re not as easily surprised! ... it doesn’t mean adopting an entirely theoretical outlook on life, but to see the things as they are, without exaggerating nor making understatements – you look at the facts and weigh how bad a thing really is.” (Anne). However, some situations are characterized by the voidness of applicable strategies. Hospice volunteers regularly experience clients that are unable to communicate and knowing what and if they perceive the volunteers’ action is a difficult undertaking. While most volunteers felt the need to act, to do something with the client, others voiced that to just endure the situation of being with the client without doing anything is a skill often needed in hospice: “we do not know what the brain still processes. If one is in coma, you can still read to him, play music and even though

it seems that he is not reacting, we do not know what he hears” (Sahra); enduring didn’t feel good in my last case. Just sitting there was highly difficult ... I read her stories, but it didn’t bring about any reaction ... for five days, just sitting there, occasionally taking her hand, was hard. It was difficult.” (Barbara). While enduring already hints at the fact that strategies cannot always guide volunteer action, the often-cited notion of situated flexibility is both a strategy and a general characteristic of the volunteer. With rapidly changing client states, resorting to fixed strategies becomes impossible, so that volunteers need to rely on a momentarily, flexible and adapted response to the client: “I am acting dependent on the situation ... you can well prepare a strategy, but in the end, the afternoon will suddenly be entirely different. Suddenly, it becomes important to the client to visit the graveyard. Suddenly, there are stomach problems. Suddenly, pain intensifies. And you have to react to it, having a fixed strategy is difficult then” (Lynn).

Category 4 – Pure-Altruistic volunteer motivations

The interviews revealed that all participants were motivated, at least partially, by altruistic motivations pertaining to the class of pure altruism. Note that having pure altruistic motivations do not exclude having pseudo-altruistic motivations at the same time, as was often the case. First, an overview over the pure-altruistic motivations is provided; second, implications for mental health are discussed; third, implications of the perception of meaningfulness are described.

Volunteers described pure-altruistic motives usually as an inborn quality of their personality or a trait that they have continuously recognized for most of their lives: “helping others is the most natural thing in the world to me and I do not spend much thought about it. If someone needs help, I simply help without thinking much about it ... I do not want a red carpet for it! I like doing it without giving it much thought, it is simply a good feeling” (Lynn). Others perceive their altruism as a form of giving something back to society, or as a means of being thankful for their own, relatively harmonious upbringing, parental love or as a result of general satisfaction and well-being in life: “I am of the opinion that I had a lot of luck throughout my life ... Perhaps I feel the desire, to give a piece back of it. It sounds like a cliché but that’s how it is. I don’t know why I’d be doing it unless for that” (Kate); “but I am also satisfied, because I have been given the life of my parents to my hands, and all the love I received myself, I’ve been giving back. This gives me a good feeling, satisfaction” (Lynn). When asked to describe how volunteers would characterize their altruism, most provided

description pertaining to the notion of being there in a state outside the ego, referring to the moral conviction that dying clients deserve authentic-empathetic attention to counteract their lonesomeness during death: “it was simply important that no one dies alone, that if you have to take this difficult path, you do not have to do it alone.” (Lynn); “being there means: holding the hand, reacting to needs and desires of these people that need to die. And for me, that means being there” (Lynn); “certainly there are a lot of people, who, when severely ill, are alone. And I couldn’t stand it” (Kate). For some volunteers, achieving such empathetic attention was condition to leaving the ego outside: “you have to leave your own ego out. It’s not playing a role in there. It is important to satisfy the other” (Lynn). Yet, other volunteers did not so much describe conditions of giving back, but motivations of doing good that pertain to universal moral norms and being a morally good person: “I think that by helping others, my actions become moral ... I strive to do things not just for myself but for society at large” (Anne). For them, giving back is a means of achieving morally sound action with benefits beyond the volunteer herself: “I try to act morally good ... so that I do not just do these things for myself but also for the benefit of others. I simply want to be a decent human being, who is not asking anything back” (Anne).

Second, volunteers describe that, concerning their pure-altruistic motives, mental health outcomes revolve around feeling satisfied and happy as a result of being successfully able to help. Clients often respond to this help by expressing appreciation, which in turn fosters positive affect at the side of the volunteer: “I know that I’ve helped him. And it released such feelings of happiness! ... the other was happy, said thank you, and I was happy about it. I believe that happiness hormones get released so that you feel good and well doing it. ... but after all: you know that you gifted a good afternoon to another human being” (Barbara); “I try to sense their wishes ... but you do not always get a clear answer, sometimes this is difficult. And when you now that what you did was exactly right for the client, it is beautiful! ... I am happy when I hit the sweet spot, when I think: yes, this is exactly that what she wanted!” (Barbara). Sensing and responding selflessly to other emotions and desires is intrinsically rewarding because it provides the volunteer with a sense of achievement. Others have highlighted the fact that this empathetic sensing and responding is a quality of interaction that is lacking in everyday life: “you get so much happiness and luck back from them, they are happy when you visit, when you hold their hand, when you put your arms around them ... so much is coming back, so much satisfaction, luck and thankfulness that it is simply a good feeling, and a feeling not often existing in the real world” (Lynn).

Third, the notion of hospice volunteering was prevalent throughout the interviews. Volunteers felt that doing hospice work was an intrinsically meaningful activity benefitting clients and society at large: “not just vegetating but taking an important role in society. It is important to be to do meaningful work and that I am important to others” (Anne); “but at the same time, I wanted to do something voluntary ... it was looking for an activity, but for a meaningful activity!” (Leora). Doing meaningful work seems to be connected to receiving respect for executing this work. Volunteers report receiving respect from society for doing this seemingly difficult job, and in return, the received respect makes them feel good: “if people do this work voluntarily, it is very respected. Most don’t dare to do this kind of work. If someone does it voluntarily, then people will pay them respect and I believe this makes me feel good” (Anne); “Sure I want that people respect and value me for what I do. ... I’ve been elected by them, because they expect something from me. And I would like to fulfill that. And I surely would like to be appreciated for it, or at least respected! ... it gives me a good feeling when I have the feeling of doing it right” (Sahra).

Category 5 – pseudo-altruistic volunteer motivations

Throughout a multitude of interviews, volunteers voiced the idea that, for them, hospice volunteerism is a form of preparation, either in view of their own death or for their professional job. We discuss hospice volunteerism as a preparatory strategy first, followed by a brief discussion as to which pseudo-altruistic strategies are used in relation to mental health.

First, participants voiced that taking up the volunteer course and doing the volunteer work afterwards was a means of preparatory self-interest behavior. For some, doing the volunteer course helped prepare for the care of own dying relatives: “because my parents were ill and old, I thought to myself: ‘you gotta prepare for what’s coming up!’. I thought that I could be looking for support in the course!” (Barbara); “I admit that it is self-interest ... but also a lot of preparation, when suddenly something serious happens. I know the steps that I’ll have to take and that’s better than coming from outside, knowing nothing” (Barbara). By participating in hospice work, volunteers get to know the local hospitals, doctors and administrative structures, allowing them use this structural knowledge either for themselves or for the good of their relatives: “when I myself have to go to hospital, then it is easier to engage with the people there ... then I know which steps I can take or what I can do” (Barbara); “for me it is also preparation ... my parents both still live, but I already come to terms about their death. And when – one day – my parents go into their dying process, I’ll be

more knowledgeable” (Leora). Hospice volunteers most often had a clear idea about finiteness of their own life, and by continuous confrontation with this topic during the preparatory course for volunteers, often developed an accepting stance that involved making clear plans for how they would like their death: “a friend of mine told me about the contents of the course, and that he is now better able to deal with his own finiteness. Since I am personally thinking a lot about my own finiteness as well, I thought that the course could help me deal with my personal reasoning as well” (Anne); “I think because through volunteering the topic is more present. When I am counselling older people, I am not myself in that situation, so I don’t know what I would do or what I would think. But at least I have seen different models (of dying) and thought a bit about them” (Leora). It so appears that by experiencing actual deaths and the action-interaction that dying clients face within the medical care and hospice system, volunteers start perceiving their work as a means to collect information, reducing uncertainty in their own life. Yet another form of how the hospice volunteerism is a means of preparation concerns the exchange of knowledge between a paid job in care work and the hospice volunteerism. Many volunteers had a job in the medical or care-related fields and found that there was a mutual exchange between their job and their volunteerism: “because I want to become a psychotherapist later on, the course was a preparation for me, an exercise in dealing with sad persons, but also seeing that I’m good in providing comfort! ... I think that someday, mourning clients will come to visit me, and as the course prepared me to learn about stages of mourning, I can probably deal better with these clients later” (Anne); “or trying to integrate them into the end-of-life counselling or into my job cause me a positive feeling, well-being, that results from doing something good” (Leora). At the same time, having previous experience in care jobs can influence the decision to take up the volunteer work, also by the desire for supervision, that is often lacking in the usual nursing practice: “I really was sure that I possessed the required resources through my job at the care center, I was totally sure!” (Kate); “my job is being a nurse ... and accompanying dying individuals was something I have always done ... when I heard that there was a new hospice organization constituting in town, I thought that I could do it in the organization and in a supervised fashion” (Sahra). Another motive pertains to the realization of personal values and ideas in an organizational context. While this was reported less common, one individual felt that shaping organizational processes was something they could do through working in an administrative position at the hospice organization administrative level: “When you take responsibilities, you’re able to sculpt things. And you can only do that, if you’re in administrative position and surrounded by people who support your vision. If you’re able to

sculpt things according to your vision, it gives you big satisfaction” (Sahra). As such, seeing your personal visions grow can be intrinsically motivating. At the same time, working at the management level of an organization is appreciated by its members and other administrative members: “Sure I want that people respect and value me for what I do. ... I’ve been elected by them, because they expect something from me. And I would like to fulfill that” (Sahra).

Second, healthy egoism was a strategy concept often named. Healthy egoism is a notion regarding personal boundaries, from becoming aware towards protecting them during the volunteer work: “healthy egoism is good, it means thinking about yourself, not having a helper’s syndrome, but at the same time to not lose focus for the greater good ... I always preserve a good, healthy egoism. Somewhere there has to be a boundary if things become too much for me” (Anne). Boundaries can revolve around which client groups the volunteer wants to counsel, whether they want to exclude clients that are too similar to them or too demanding. Healthy boundaries allow for a sufficient level of contact but prevent becoming too interwoven with client family dynamics: “Sometimes it is the case during palliative care work, that you depart from your path and get too much involved into family systems – you start to suffer, wear out, become unsure or do not know if your behavior is right. ... There are situations, where you do not know anymore where your boundaries are, and therefore, the feedback from the organization is valuable” (Sahra). As such healthy egoism in terms of boundaries is a strategy that prevents volunteers from emotional overload. While boundary setting is not in itself purely pseudo-altruistic, it stands in contrast to the idea of selfless helping and exhibiting a helper’s syndrome. As the concept aims to strengthen the ego (instead of indulging in “egoless” helper’s syndrome rhetoric’s), it is classified as pseudo-altruistic.

Category 6 – The client-volunteer relationship

At the heart of hospice volunteering lies the trusting relationship between volunteer and dying client. First, results show that the purpose of this relationship serves is to reduce stigma and to create a congruent patient-centered atmosphere of exchange. Second, volunteers used a variety of strategies to build and sustain a good and congruent client-volunteer relationship. Third, the mental health implications of a successful client-volunteer relationship are discussed.

First, most volunteers recognized the successful establishment of client-volunteer relationship as a tool to overcome stigma about the concept of hospice that is still pertinent in society: “dying is a taboo you’re not supposed to talk about. I’ve often seen that, when people died within the family, that they refused to talk about it” (Anne); “... most do not have an understanding of how a hospice works ... of course you’re sitting together with dying individuals, but not like people imagine it. It is not sad at all!” (Kate). Facing such false assumptions, volunteers described that a large part of making contact with clients pertains to addressing, and – if necessary – correcting such erroneous beliefs. Yet others see that the successful communication about the subject already reduced stigma to some degree: “during the last 15 years, much has happened, people know more about what a hospice does and that hospice is not automatically equated to certain methods anymore, although for some hospice is still a red flag” (Kate); “we have to inform the parents about the project ... and many parents are totally shocked at first” (Kate; i.e. a project in primary schools where children learn about what mourning is and how it can be dealt with healthily). The goal of stigma reduction can only be achieved when the volunteer is able to act in a congruent, patient-centered manner. For many, patient-centeredness involves having enough time available: “it is the relationship that can be enacted between two persons, without thinking about something different or having another appointment in my head; really the single most important factor is time, that is my biggest motivation”; “it is a certain luxury ... that you can gift all the necessary time the individual needs” (Eva). For others, patient-centeredness is achieved by exhibiting congruence by introducing personal values into the client relationship: “when I can exhibit my values outside or when I am trying to integrate them into the end-of-life counselling or into my job, it causes me a positive feeling, well-being, that results from doing something good” (Leora). After all, the exchange in a client-volunteer relationship can, with time passing by, resemble characteristics of a friendship: “it does something to you. Something builds up. I do not want to say it’s a friendship, but cohesion. And you cannot prevent it ... that simply is the essence of volunteerism” (Kate).

Second, volunteers used different strategies to form a positive relationship with the client. However, only few participants were able to provide concrete descriptions. In some client relationships, breaks occur. Clients can reject the volunteer at any point in time or suddenly to not want the hospice service to continue anymore. At the side of the volunteer, such situations can be perceived as stemming from personal characteristics, but learning to view breaks in the relationship as a normal occurrence pertaining to cognitive decline in death is difficult and not always easy: “this woman didn’t want to see me anymore and it was

horrible for me ... it turned out that she broke contact with her entire family ... but it affected me personally so much because I involved myself too much: I went to her birthday, I went to her in a private role”; “I now learned, that this rejection wasn’t against me personally, but is part of the dying process ... but realizing this was a learning process” (Kate). In addition, volunteers learn to differentiate the psychosocial situations where they are actually able to help versus those, where they cannot exert influence on. Recognizing where helping is effective serves to protect resources of the volunteer, prevents enmeshment and allows for precision: “although I would like to have impact on these situations, I know it’s not our task, we would enmesh ourselves ... we should not do it, albeit I’d like to” (Kate); “I look where I can help, where I can really effect something” (Sahra). While the overarching goal is to achieve a client-centered mindset in the relationship, volunteers may decide to divulge personal experience to open up the conversation on difficult topics or to introduce a degree of personality beyond the professional role: “it’s an exceptional situation, so I divulge more from my personal life ... I can convince them better that things will work out when I am not only citing from the books but from my personal experience” (Kate). Regulating distance and closeness is another strategy mentioned by the volunteers. Most were of the opinion that being too close, too allowing in a client relationship can turn malicious. In other cases, when clients ask for services beyond core tasks of hospice, volunteers need to regulate the distance towards the client: “I do not start providing care work. I do not start living in their household. These are all intrusive things. I do not meet with them privately. I end the contact when the client has died” (Sahra); “I developed a friendly relationship with his wife, or at least something similar to friendship, because I tend to involve myself too much when there is encouragement between us, but one shouldn’t do it, keep your distance, but it’s not always easy” (Kate).

Third, mental health outcomes in the volunteer-client relationship seem to stem from the experience of self-efficacy. Volunteers feel needed and when their actions successfully correspond to these needs, volunteers feel affirmed, appreciated solicit feelings of self-efficacy: “and I had the impression that I was able to effect something, and if only at a very small scale! That was fulfilling and felt good to me ... I had the feeling of being needed, and that’s good”. Experiencing self-efficacy can exert itself in positive affect.

Category 7 – The organization

Three major categories characterized the role of the organization. First, the organization has the function to provide a forum for interpersonal back-up resources. Hospice volunteering can be a demanding task for the volunteer, and all interviewees expressed appreciation for the fact that they could always rely on the back-up resources provided by the organization should need arise. At the same time, volunteers receive appreciation from the organization, that values their engagement for dying individuals. Interpersonal backup is provided through the organization by different means: the administrative board of the hospice organization offers individual counsel on problematic situations, while external psychological supervision can offer a view from outside. Lastly the volunteer group cohort itself, whose meetings and activities are scheduled by the organization to foster exchange and feedback, can act an organized form of interpersonal backup: “you get backup through exchange, at the group meetings ... but also in consultations with the administrative board, they guide you during your process and provide supervision. Getting feedback is important to know, whether you’re on the right track.” (Sahra); “I never felt left alone. I always have the feeling that there is good backup ... knowing that there is someone I could talk to is important for me” (Leora); “we always have the option to ask for advice or help, regardless in which matter. Knowing that I have this option is good” (Kate).

In most cases, volunteers turned to the administrative board of the organization when there were in need of advice from experienced full-time hospice workers or when they felt rejection from clients: “and I did not know how I could make an appointment or speak to the doctor ... I called the coordinators many times and asked for advice on how to proceed” (Lynn); I was responsible for applying morphine patches ... I was so unsure that I applied the morphine again, and she entered such a deep sedation that I thought: you killed her! Then I could call our coordinator and ask, and it was very important to receive a qualified answer” (Lynn).

Another resource of interpersonal support is the provision of external supervision. With the organization paying external psychological supervisors, volunteers are given the opportunity for both individual and group supervision sessions, if need be also in private one-on-one conversations. Supervision was often used when volunteers felt uncertain about whether they were still acting within their boundaries or were facing more difficult problems with clients. In these situations, asking someone external for help was experienced as helpful: “I felt really hurt and had doubts whether I’d done something wrong. I joined a supervision

where the psychologist explained to me why this woman did this” (Kate); “having certainty that there always is someone available which you could turn to is important ... knowing that there is someone who is more experienced and has the necessary skillset is so important” (Leora). Especially situations where clients reject (some aspects of) the volunteer were talked through in supervision: “I had the feeling that I just wasn’t matching to him. And I was uncertain: how can it go on this way? This was a situation where I spoke to my supervisors about how to go on” (Leora); “I learned that this rejection isn’t against me but is part of the dying process. I do not feel attacked personally anymore” (Kate).

The group cohort of all volunteers comes to act as a resource of interpersonal backup. Volunteers characterized hospice work as team activity, and valued group activities where they were able to share experiences with fellow volunteers. These meetings differ from external group supervision in that they are more informal and less methodologically structured. One volunteer highlighted the fact that sharing experiences with other volunteers normalizes her view, providing validation and a shared reality: “by exchanging experiences with one another in the group, you normalize everything and realize that others had similar experiences. By this normalization, I am able to stay on the factual level and see things realistically ... it is a shared reality” (Anne). Yet other volunteers have highlighted that group-processes support collective decision making in order to find a professional solution: that “it is an exchange of experiences, where we’re supporting each other and when someone asks for advice, we’ll discuss about the matter and try to find the right way collectively.” (Kate).

Second, the organization is concerned with fostering institutionalization and professionalization of the hospice profession. Stemming from Christian roots, hospice volunteering has traditionally been a voluntary activity from citizens. Through the increasing cooperation with palliative medicine, hospice organizations sought to professionalize themselves by institutionalization. At the same time, volunteers themselves can be motivated by the wish to act more professionally and with the support of an institution: “the organization was founded from a Christian woman’s movement, without competency in care but driven by citizen engagement ... when I heard that there was a hospice organization constituting in town, I thought that I could do it in the organization and in a supervised fashion” (Sahra). Institutionalization also involved the ability to receive funds from health insurance agencies, albeit at the cost of increasing bureaucracy. For some volunteers, this was at the cost of the initial idea of pure altruistic helping: “it was connected to a lot of regulations and laws, it was in its beginnings. The thought of simply going to the bedside and help was still there, but it

went to the background as a result of professionalization” (Sahra). Nevertheless, volunteers did feel that professionalization brought about wider means of advertising the hospice idea to the general public, resulting in reduced stigma: “hospice is not automatically equated to certain methods anymore, although for some hospice is still a red flag” (Kate).

Third, the organization has a regulatory function pertaining the conduct to professional standards of interaction. This entails prevention of intrusive actions towards the client while at the same time protecting the mental health of the volunteer by recognizing instances where helping becomes too draining. Many volunteers acknowledged themselves as having a “helper’s syndrome”, however in some instances, volunteers exhibit limitless helping behavior to feel better about themselves or to distract from personal problems. The organization as a regulatory body is obligated protect these individuals by observing, and if necessary, regulating their behavior: “the basic training course is to weed out these people, because most of them do not have a position towards death ... if we see that they develop a personal position towards it, they are allowed to continue. But sometimes we recommend to not volunteer and say: search for help!” (Sahra). While this serves to protect the volunteer, in other cases, the organization has to protect the client from intrusive volunteer behavior: “you cannot allow that everyone is doing as he pleases. You cannot let the volunteers impose their values onto the client ... our job is not to evangelize or to impose our own convictions, that is intrusive and bad” (Sahra).

Category 8 – The volunteer-organization relationship

The relationship between volunteer and organization is a participatory exchange of resources process. In this exchange, volunteers give resources to the organization and in turn receives resources back from the organization. Another focal point in this process is the group cohort of all volunteers, that provides the frame of reference in which the volunteer-organization exchange can occur.

Time is the most important resource that the volunteer donates to the organization. The donated time is the motor of the organization that helps realize the organization's main goal: providing end of life care free of charge for the clients. Volunteers experience their hospice work as qualitatively different from paid labor, in that they both give and take time resources to and from the organization: “by giving your own free time to the organization ..., I believe that you are giving something back because you invest your time ... I will spend more time with hospice work because I really enjoy it and it makes me feel good” (Lynn); “I

would say it is a give-and-take. ... you get much back, giving and taking is a balance somehow” (Leora). In turn, organizations give appreciation back to the volunteers for donating their free time. When it comes to the function of time as a resource, it serves to create a free space to the client and his family – during the time the volunteer is present at the clients home, the caring relatives are free to leave and do chores other than caring for the dying individual, e.g. doing something for themselves or driving into the city: “I gift the family a free-space” (Leora); “at the same time, her daughter was really thankful that she was able to go shopping or simply go away for a hour” (Leora).

When it comes to the resources that are given from the organization to the volunteer, the most important one is the transfer of knowledge. Volunteers undergo extensive training in hospice and palliative care methods, communication skills and group dynamics. These organized trainings represent an effort of professionalization of hospice (remember its roots in the civil rights movement!): “you really get a lot of qualified knowledge ... these evenings were super informative! ... before I joined the hospice, I did not know many things but did them by intuition. But with my knowledge today it got a lot easier!” (Lynn). However, the organizational knowledge transfer does also serve the purpose of weeding out candidates, who lack personal stability to become hospice volunteers: “the basic training course is to weed out these people, because most of them do not have a position towards death. The basic training course is not as popular as the follow ups, because people get confronted with themselves, their biography ... if we see that they develop a personal position towards it, they are allowed to continue. But sometimes we recommend to not volunteer and say: search for help!”.

Another resource provided by the organization is reassurance and confirmation. Volunteers can be confronted with ambiguous situations that feel challenging and uncertain. The organization communicates to be open for discussing these questions and to provide counsel regarding these situations. When volunteers receive these confirmations, personal uncertainties are reduced: “... getting confirmation, that it what you’re doing is right! It’s important to reduce uncertainties, to learn from your own mistakes, to reflect ...” (Sarah). Most volunteers described a culture of mutual feedback as the organizational enabling component for personal growth. This mutual feedback is perceived as a means of interpersonal-backup, to which the volunteer can turn back if need arises: “you get a lot of backup at the group evenings where there is exchange, where you can talk about your clients, where you get resonance from others. Also by speaking to the coordination or supervisors. Getting feedback is really really important so that you know if you’re on the right path.

Sometimes it is the case during palliative care work, that you depart from your path and get too much involved into family systems – you start to suffer, wear out, become unsure or do not know if your behavior is right. ... There are situations, where you do not know anymore where your boundaries are, and therefore, the feedback from the organization is valuable” (Sarah). Note that the organization is providing reassurance by first, offering guidance themselves (from the coordinators), but also through organizing group evenings and supervision, where volunteers and external supervisors can meet. As such, the organization is in the dual role to provides resources themselves but also to provide space for intra-group support between its volunteers and external supervisors: “there is supervision where you reflect on why you want do it. By this, I got a clearer picture that I was capable of doing it” (Leora).

The group cohort of volunteers is the executing heart of the organization and as such participates in resource exchange. Volunteers see themselves as representing the organization as a whole and thus strive for internal exchange: you are a representant of a collective” (Anne). Group meetings offer a forum for exchange and allow the sharing of sensible information that cannot be shared outside with other individuals: “we did circles where everyone told the group about their own experiences with mourning and death. ... By doing so, the organization fostered that we were able to speak about it, by organizing the exchange” (Anne); “the organization provides opportunities to learn ... I can get feedback and reflection from the organization. The organization builds the pre-conditions that I act upon. Afterwards, I get feedback and help that allows me to develop and evolve further. And in the end, I can return everything to the client. It’s a circle, it belongs together” (Sahra). By having a shared body of experience, group members engage in mutually validating and normalizing their experiences: “by exchanging experiences with one another in the group, you normalize everything and realize that others had similar experiences. By this normalization, I am able to stay on the factual level and see thing realistically” (Anne).

Category 9 – Mental health as a result of resource exchange: fear-reduction and appreciation

Volunteers experience a reduction in perceived fear about death and dying as a result of volunteering in hospice settings. Fear reduction was achieved by both egoistical motives (reassurance through obtaining structural knowledge) and altruistic motives (fear reduction through repetitive communicative habituation). In both cases, receiving appreciation from the organization and the clients themselves served as a reinforcer of this phenomenon. Mental

health outcomes pertained to the adoption of a more calm, self-accepting mindset and advances in self-esteem.

First, volunteers are able to reduce personal fears about death by obtaining structural knowledge about the local hospital infrastructure, the local doctors and local funeral practices. Having such structural knowledge equates to a reduction of uncertainty – knowing what infrastructure and processes will apply in case of one’s own death is reassuring in itself: “this is also a bit of self-interest behavior, but also a lot of preparation so that one is prepared when something serious happens. And I know the steps that I will have to do compared to someone who comes from outside knowing nothing” (Barbara). For other volunteers, this structural knowledge came from caring for sick relatives and was not obtained from the hospice volunteering: “for me it is also preparation ... my parents both still live, but I already come to terms about their death. And when – one day – my parents go into their dying process, I’ll be more knowledgeable” (Leora). Either way, it is the imminent personal experience with the structures and societal practices of death that serves to reassure: “one is dealing much better with it, because you simply lived through a diversity of situations, you’ve witnessed a diversity of dying processes ... and you deal with it calmer, more at ease, you’re able to adjust better, because you’ve simply already lived through them!” (Sahra); “... because you’re not supposed to be fearful anymore! You will need to go on this journey, whether you want it or not. But you embark on it calmer, at ease, because you’ll know what will await you!” (Lynn).

Second, the repeated communication about death, dying and related societal practices habituates the volunteer, so that, ultimately, death is increasingly perceived as natural part of life that can be approached with acceptance: “through the constant processing of the topics dying, death and mourning, and through constantly experiencing death through my work ... habituation kicks in. The topic loses its fear. Fear gets smaller, because one has to constantly process it. And if you start thinking about your own death, fears are not as big but have the size they ought to. The constant confrontation habituates you to the topic.” (Sahra). Organizations therefore provide a meaningful forum for death-related communication by organizing group events and providing educational courses on palliative volunteering, in which volunteers are repeatedly exposed to these topics and learn to develop an accepting own position: “through this course, I became less impacted by fear. When I used to think about my own death, I now see that it is normal ... one learns that contrary to our society, this topic belongs to life and shouldn’t be kept silent” (Anne); “we did group exercises sitting in a circle that entailed talking about death and morning. Everyone had to talk about their personal

experiences and the organization fostered the discourse about it by organizing these activities” (Anne); “these group meetings are very good because we can exchange with each other. We always have the option to ask for advice or help, regardless in which matter. Knowing that I have this option is good” (Kate). Such an accepting position of death is a result of purposeful learning processes, and contrasts with the often-far-reaching stigmata existing in the general population. When volunteers have developed a personal position concerning death, they often felt enabled to enact in direct contact with the client, again, through communication: “my communicative abilities became decidedly better! I learnt this through my many courses and seminars ... I am good in speaking about difficult topics, and I can communicate to the point very rapidly, without crossing boundaries and without becoming intrusive” (Sahra).

Third, fear reduction is re-enforced by the exchange of appreciation and gratitude between volunteer, client, and organization. Clients express their appreciation and gratitude towards the volunteer to thank for being there or for allowing their relatives a much-needed break from care: “when you’re directly working with clients and their families and there were situations where you made things easier for them, they express their appreciation, it is then very present ... they say: without you, I would not have been able to do that” (Sahra); “her daughters were really thankful that they could leave the house for one hour to do groceries” (Leora). The organization shares appreciation for the fact that volunteers take up the task besides their paid labor so that appreciation becomes the “currency” of compensation; at the same time, volunteers feel confirmed and re-affirmed in their actions by receiving organizational appreciation: “(appreciation) is the only compensation we get as volunteers. We’re not getting paid” (Sahra); “and then you can contact the organization ... they can provide re-affirmation by giving you appreciation!” (Anne). Lastly, volunteers can feel appreciation for having this learning opportunity, and in return, share their appreciation with organization and client: “but I am also thankful that I was allowed to this work, that the family permitted it ... I am foreign, not a member of this family. And I appreciate that the family gave me trust and let me enter” (Sahra). Often times, their work is appreciated by friends or other members of society, resulting in verbal expressions of appreciation: “often times, you’ll get appreciation form others when you tell them about the job, and they say: wow, I couldn’t do that” (Leora); “I get a lot of positive feedback from others ‘wow, you’re doing great albeit it is such a difficult task’” (Barbara); “people recognize that you’re doing this difficult job. But because you’re doing it nevertheless, you receive appreciation” (Anne).

Lastly, the mutual sharing of appreciation between all involved actors, a concept that differentiates hospice volunteering from regular labor, serves to impact mental health in

almost all narratives. Volunteers reported a variety of generally positive emotions as a result of their interactions in unison: “getting so much back is simply a good feeling that is often lacking in the real world. But in hospice work, it really occurs often!” (Lynn); “trying to integrate them (personal values) into the end-of-life counselling or into my job cause me a positive feeling, well-being, that results from doing something good” (Leora); “if I was able to help someone, you receive appreciation. People thank you and tell that you were able to make an impact. And this makes me feel good, is good for my ego, my self-worth, it makes me happy” (Sahra). Besides this diffuse positivity, volunteers described concrete results stemming from the work. First, some volunteers became calmer, often exhibiting itself in the fact that volunteers do not get upset as easily as they used to before taking up the volunteering: “I am more relaxed about things which I used to be upset about ... now I think: it is as it is, I cannot change it.” (Barbara); “when I am allowed to guide others, I become really well-balanced ... there is also a certain calmness that gives me great satisfaction” (Lynn). Developing a calmer, more accepting stance towards life may well stem from the realization of the finiteness of life, and the repeated exposure to this fact throughout volunteering: “everything will end. One cannot take something with you!” (Barbara). Yet for others, becoming more accepting and calmer stemmed from the realization of how different clients and their families mourn: “because I got so many different insights, I developed a bigger tolerance because everyone deals differently with dying ... everyone mourns differently. Everyone dies differently and that’s why there is a bigger tolerance in me.” (Leora). As a second outcome on mental health, volunteers describe a pronounced increase in self-esteem. Volunteers gain self-esteem by continued exposure to clients, but again, more so through receiving appreciation for their actions: “I realized that I got more self-esteem because I gained a certain treasure trove of experience, and this benefitted my self-esteem!” (Kate); “I would say that I got a lot more self-esteem, this surely is due to age but also due to providing end of life counselling ... you receive so much appreciation from others when you speak about it (the volunteering), that’s why I think it is a building block of self-esteem!” (Leora). Just like the factual knowledge that volunteers exchange between professional job and volunteering, benefits in self-esteem transform the actions of the volunteer beyond volunteering itself: “I felt able to confront my boss and I felt able to say things to him ... which I would’ve never done before! ... I don’t believe that I would have done this without the self-esteem from working in hospice” (Barbara). Self-esteem is also re-enforced by the organizational culture of communicating appreciatingly with each other: “every step is totally valued! It’s not swept under the table, but it is really appreciated, and that’s good for the soul”

(Barbara). Acting with confidence and self-esteem also feeds back to the expectancies that clients and family place upon the volunteer. Facing high uncertainty in death, families expect the volunteer to lead the conversation as an expert in palliative care: “And they have certain expectancies towards you. When you come to their home being not self-confident, then it is difficult because you are expected to lead the conversation” (Kate).

Member check

Participants were present with the descriptive summary memo and with the main points of each category. Generally, they recognized the theory at a global dimension in themselves and deemed it fitting with their experience.

Participants strongly agreed to the experience of a personal learning journey (category). However, participants did not agree with the term “stigma” that was thought to still pertain in society about hospice, but preferred the term “taboo”, reasoning that the act of dying itself would represent the stigmatized occurrence instead of the hospice idea itself. There was complete consensus over category 2 (culture of dying), suggesting that participants were aware of the impact cultural norms and institutional practices impose on their actions.

Concerning category 3 (the volunteer), participants acknowledged that many hospice volunteers work in medical jobs or related fields but disagreed on the idea that there is continuous exchange of knowledge between paid labor and volunteering. The volunteer role was described as so fundamentally different as compared to their professional roles in paid labor, stressing that both would differ in terms of their client mandate – this difference of mandate would forbid the mutual exchange of knowledge – clients expect different resources to be provided from medical and hospice providers. Furthermore, participants disagreed about the motivation of hospice volunteers wanting to respond to their perceptions of lacking time in the medical model: the participants did not experience the medical field as a strictly separate entity; there would be no need to “compensate” lacking time. Instead, all participants suggested to view hospice and medicine as complementary entities similar to gears engaging which each other.

All altruistic motives from category 4 were recognized in unison, and there was no doubt that all participants shared them in their experiences.

Pseudo-altruistic (category 5) motives were largely regarded as accurate. However, not all participants agreed to the claim that volunteers seek to obtain structural knowledge

about local medical structures. While they did not deny the possibility of this motive, it was thought to occur only in some rare cases.

The description of client-volunteer relationships (category 6) was thought of as accurate, but the strategy of divulging reared some major concern. The participants pointed out that the dying client should represent the center of all action and that divulging personal information of the volunteer would be of no priority. In extreme cases, divulging could be detrimental to the client-volunteer relationship as it changes to focus of exchange towards the side of the volunteer while disregarding the clients need for complete attention.

Describing the role of the organization (category 7) was especially difficult to these participants that were members of the administrative board themselves. There was unison consensus about the role of interpersonal resources and shared appreciation, but one member highlighted that collective decision-making as a resource would not happen by the organized group meetings but occurring strictly limited to supervision. There was rather strong disagreement about the role of professionalization and seeking distance to the hospice movements Christian roots. Proposing distance to Christian ideas as an organizational goal would discriminate volunteers of Christian faith, disregarding their work as volunteers that is often strongly motivated by their religion. As many members of the organizations were Christian, seeking full distance from Christianity would not describe the organizational goals well. Instead, participants suggested “becoming open” to atheist-humanistic worldviews represented by efforts to match the faith of volunteer and client when deciding which person should counsel which client. Concerning interpersonal resources, most agreed on their importance.

There was consensus about the description of the volunteer-organization relationship (category 8), albeit two members suggested to describe the organizations training courses as “Fortbildungen” instead of training. However, these linguistic subtleties are hard to be appropriately translated to English.

Participants described the resource-oriented perspective of mental health (category 9) as new to them but agreed to the idea of appreciation as a fostering resource. Two participants highlighted the fact that most volunteers could not always expect appreciation from their clients, and in some rare cases, appreciation could be fully absent. However, in these cases, the participants described their use of interpersonal resources, providing further validation for perceiving them as promoting resources for mental health. One participant stressed that “sometimes, appreciation has to grow before it can be exchanged”, hinting at the fact that the

proposed model assumes its existence between the involved actors right from the beginning of their relationships.

Discussion

Aim of the study was to investigate how hospice care volunteers come to experience mental health related to their motives and strategies for volunteering. Results indicate that volunteers perceive their work as a relational process, where exchange processes of appreciation between group cohort, organization and clients exerts positive influence on their mental health by fostering perceived self-efficacy and reduction of personal fears. Yet, current debates on volunteer motivations have abstained from describing such exchange processes. The findings compare to Ryff's theory guided dimensions of positive psychological well-being, that described such give-and-take dynamics.

Exchange processes as a lacking dimension in quantitative measures

There was high similarity of motives compared to the scales of IMHPCV and VFI in that both pseudo-altruistic and true altruistic motives were present in the volunteers narratives. These findings verify Seibold (1987 as cited in Claxton-Oldfield, Fawcett & Wasylkiw, 2004), who argued for a two-component structure of hospice volunteer motivations divided into pseudo- and true-altruistic motives. Concerning pseudo-altruistic dimensions in the VFI, similarity was especially high at the *enhancement* dimension, where volunteers reported an increase in positive affect in that they became less fearful and calmer by repeated communicative habituation and obtaining structural knowledge, and that these processes represent development of the ego as proposed by Clary, Snyder, Ridge et. al (1998, p. 1518). While previous research on the effects of volunteering already hinted at increased levels of positive affect (Kahana, Bhatta, Lovegreen & Midlarsky, 2013; Kahana, Bhatta, Lovegreen & Midlarsky, 2013) and positive influence on mortality (Harris & Thoresen, 2005; Brown et al., 2003), fear reduction is a novel mental health outcome that has not been discussed extensively in literature yet. It could well be the case that fear reduction by habituation is an ego-strengthening strategy in itself, thus belonging to the enhancement scale. The *understanding* scale (Clary, Snyder, Ridge et. al, 1998, p. 1518) was present in every narrative, highlighting that volunteers appreciated the chance to obtain new knowledge in a personal learning journey.

Concerning true-altruistic motives of the VFI, hospice volunteers perceived their work as a means of expressing personal altruistic and humanitarian *values*. Wanting to counteract the lacking time for patients in the medical model, volunteers expressed compassionate humanitarian ideals to ensure the best possible care for dying patients by gifting them with their time resources. Lastly, volunteers expressed differing motivates pertaining to the *social* scale: favorable, appreciating judgements from outsiders about their volunteer work were often described as beneficial to their experience of self-esteem and served as extrinsic reinforcement. This highly corresponds to the view of Clary, Snyder, Ridge et. al (1998) who described social motivation as “engaging in activity viewed favorably by important others” (p. 1518)

At the pseudo-altruistic side of the IMHPCV, the *leisure* dimension, itemizing volunteering as a hobby, was present in that volunteers expressed having taken up volunteerism as a result of personal interest existing from earlier experiences in their lives. It seems that personal interest is conceptually different to the common conceptualization of “hobby”, as the volunteers dominating motives were most often a result of personal experience or witnessing deficits in care. The item wording of the IMHPCV leaves space for interpretation of leisure as a hobby, possibly confounding with personal interest. This seems to reflect the fact that only the leisure scale showed a significantly lower internal consistency rating than any other items (Claxton-Oldfield, Wasyliw, Mark & Claxton-Oldfield, 2010, p.37).

At the side of IMHPCVs true-altruistic motives, *civic responsibility* was a common motivation in that volunteers wanted to give something back to society, often as a means of being thankful for their own upbringing. Others extended this notion by wanting to become morally good members of society. Most notably, the *altruism* scale was present in every interview and represented the single most important motive to the volunteers. All participants expressed the desire to help others, to become a psycho-spiritual helper on the last journey or to engage in self-less helping conceptualized possessing a helper’s syndrome. It is remarkable how close the wording of the participants resembles the wording of items at the altruism scale throughout all interviews, implying the fact that all participants were (at least partially) motivated by true-altruistic motives without exception. This finding is in line with the argument of Claxton-Oldfield, Fawcett & Wasyliw (2004, p. 83) and Burns, Reid, Toncar et al. (2006), holding that true-altruistic motives were most influential in the decision to join a hospice organization voluntarily.

However, there were also differences in that not all motives occurred evenly distributed among participants, and most differences were in the field of pseudo-altruistic motives. At the side of the VFI, *career* related motives for taking up volunteering were rare. Only one participant mentioned a such intention while the majority explicitly denied them. This might be due to the fact that only one younger participant participated in the study and this finding is coherent with previous research that prescribed career motives in volunteer work mainly to younger individuals (Planalp & Trost, 2009). *Protective* motivations (i.e. volunteering to reduce guilt or diverge from personal problems) were not reported frequently; this might be a representation of the hospice organizations regulatory function, that seeks to weed out volunteers that are heavily affected by personal problems. Volunteers in fact condemned the idea of helping just to feel personally better and seem to be aware of the maliciousness of protective motivations. At the side of the IMHPCV, the scale of *personal gain* relates closely to career related motives and was likewise absent, besides from single incidents where volunteers sought to obtain structural knowledge about medical environments in an attempt to prepare themselves, although this appeared not to be a strong or especially common motivation for most. For *self-promotion*, most volunteers did not do their work to feel better about themselves. It was made explicit that the organization highly disregarded this motive, and this scale closely corresponds to that of protective motivation in VFI.

While the interview data confirms that volunteer motivations are overarchingly distributed between altruistic and self-interest (Seibold, 1987 as cited in Claxton-Oldfield, Fawcett & Wasylkiw, 2004), it seems that current quantitative measuring instruments abstain from including positive procedural resources such as gratitude and appreciation in their scales. By doing so, quantitative measures are able to successfully describe volunteer motivations prior to the start of volunteering, but once volunteers actually begin with their work, process models accounting for the dynamic exchange of resources could produce a better fit for describing the complex nature of the task. The critique of Planalp and Trost (2009) holds that quantitative measures to volunteer motivations run the danger of failing to distinguish motivations from enabling conditions while process models would be able to describe the interplay between motives and resources as enabling conditions. Future process models could focus on the exchange of positive resources such as appreciation, since it shares both characteristics of pseudo-altruism (ego strengthening in response to receiving) and altruism (sharing it with others due to selfless cause).

Understanding appreciation as a positive resource

The core category “exchange of appreciation” seems closely related to the conceptualization of state gratitude in positive psychology. Albeit current gratitude research disagrees about a concise definition of the term, some researchers defined state gratitude “as an emotion that is always directed towards *appreciating* the helpful actions of other people” (McCullough, Killpatrick, Emmons & Larson, 2001, as cited in Wood, Froh & Geraghty, 2010). At the same time, there is considerable linguistical overlap between the terms appreciation and gratitude, with the Oxford Advanced American Dictionary (n.d.) defining appreciation as “the feeling of being *grateful* for something”. In the light of Ryff’s (1978) theory-guided dimensions of well-being model, exchanging appreciation can be understood as both part of the self-acceptance and positive relationships dimension. For self-acceptance and positive relationships, appreciation can be thought of as a mechanism of action or concretization of Ryff’s general descriptions of give-and-take dynamics. While Ryff’s other categories (c.f. personal growth and autonomy) are still present in the data of this grounded theory, they are not indicating appreciation as a mechanism. Instead, they would better relate to the learning journey (i.e. volunteers perceiving themselves as constantly developing) or other distal categories that are not as relational in nature as are self-acceptance and positive relationships.

First, self-acceptance (Ryff, 1989, p. 1072) pertains to the possession of positive attitudes towards the self, one’s past life as well as the recognition of personal good and bad qualities. During the volunteers learning journey, the volunteers are sensitized to the topic of death and dying, and as such confronted with self-aspects in organized courses. Developing a personal position towards the finiteness of life requires helpers to judge and evaluate about their differing self-aspects, by receiving feedback from the course group and the organization. Often this process leads to a realization of gratitude for own health and past life, causing the volunteers to understand themselves as self-efficacious agents that have a positive outlook on themselves. At the same time, their evaluation of pursuing meaningful work creates positive attitudes about their selves, exhibiting itself in increased calmness and acceptance of life and self. Positive attitudes were re-enforced by the feedback from others that often emphasized the difficult, yet meaningful character of hospice volunteering. At the same time, volunteers develop a sense of self-efficacy by perceiving the impact of their actions in real life. Feeling needed and being able to offer the right kind of help encourages positive self-evaluation, and all participants expressed increases in positive self-evaluation as a result of their work.

Concerning their past life, helpers often voiced experiences about disease and death in their own family. While not a positive account in itself, the productive resolution of these experiences provided helpers with an incentive to start volunteering. Others stated that without these incidents, they would not have become hospice volunteers. Positivity about past life thus rather applies to the consequences volunteers draw from evaluating their past life. Evaluating one's past life is part of the learning journey volunteers undertake, and it is the consequences that signify positiveness. Hospice volunteers are confronted with multiple self-aspects through their interactions both with the group cohort and clients. Educational courses at the hospice organization provide the volunteer with opportunities for experiential learning, self-reflection and feedback from other group members. These experiences seem to foster the volunteers understanding of possessing multiple self-aspects that affect the client-volunteer relationship. In their contact with dying clients, helpers are required to show situated flexibility in response to dying client's rapidly changing needs, and volunteers must be conscious about which self-aspects influence their reactions. Some volunteers even recognized the development of a professional identity apart from other aspects of their personality that they selectively active when visiting clients. While the concepts of appreciation exchange and self-acceptance share similarities, they are not exactly the same; rather, exchanging appreciation is an enabling contextual condition that supports the volunteer in developing positive attitudes about their multiple selves and the past. Sharing appreciation allows volunteers to recognize the positive impact their work has in the real world, and it is this mirroring of actual impact that helps to recognize their good and positive qualities.

Second, positive relationships (Ryff, 1989, p. 1072) pertain to having trusting and warm relationships with others, a concern for others welfare, the capacity for strong empathy and a developed understanding of the give-and-take in human relationships. Volunteers build trusting relationships both with their clients, the organization and the group cohort. Interaction with the organization was coined by an open feedback culture: volunteers engaged in collective decision making, mutual support and mutual normalization of experience with the group cohort and, in every case, felt encouraged to freely share their experiences both with the administrative board and the group. Trust in the availability interpersonal support enabled the helpers to deal with difficult situations. The concern for the welfare of dying individuals lies at the core of hospice volunteering. By often citing a relative lack of time in traditional medical settings as a strong motivator for taking up the work, volunteers express a high level of concern for the welfare of others. Consequently, volunteers understand themselves as patient-centred psycho-spiritual helpers, realizing their empathetic concern by

concrete actions that tackle the medical professions shortcomings. At the same time, most volunteers described an inborn altruistic tendency towards helping the welfare of others beginning very early in life. Most often the concern for others welfare was voiced as possessing a helper's syndrome that extends beyond the volunteers task. All volunteers understood the give-and-take dynamic inherent in all human relationships. The desire to give back to society was a strong motive for the volunteers, and albeit more on the side of giving, volunteers also engaged in taking interpersonal back-up resources with the organization and group cohort. The realization of give-and-take dynamics was most prominent in the description of mental health as a result of appreciation exchange. Volunteers donated their time, and, in return, received knowledge, feedback, reassurance and appreciation back from the organization. In contact with clients, volunteers again gave their time and emotional availability, while in turn receiving appreciation from their clients. Yet again, positive relations and exchange of appreciation are not the same; appreciation could be seen as the mechanism underlying the give-and-take dynamics described by Ryff, suggesting that it is a concretization of Ryff's suggestions in hospice contexts.

The data suggests a high convergence with Ryff's dimensions, underlining the idea that the exchange of appreciation promotes psychological well-being by being pre-condition for self-acceptance and positive relations. However, while Ryff is descriptive about the characteristics of high and low scoring individuals, no attention is paid to the procedural genesis of how individuals come to develop these traits. Although Ryff recognizes some degree of procedural genesis by stating that high scorers on positive relations "understand give and take of human relationships", she remains vague as to which resources are given and taken concretely. Possessing the ability to exchange appreciation could serve as one example resource that is given and taken and being able to share appreciation might thus function to strengthen the development of positive relations.

Limitations and weaknesses

The widespread traditional use of grounded theory to describe processes of disease and medical care was a major strength of the study. Grounded theory allowed the collection of rich descriptive data situated in the social reality of the volunteers. Limitations arise both from its sampling strategies and from the co-constructive way of developing data.

First, the process of theoretical sampling was generating large amounts of qualitative data. While this reduced the difference of power between-subject and researcher and

empowered subjects to bring parts of their own agenda to the research situation (Karnieli-Miller, Strier & Pessach, 2008, p. 279), a lot of the generated concepts were not strictly pertaining to the research question. Some participants talked more about organizational structures instead of processes of mental health. While initially perceived as digressive from the research question, organizational issues turned out to become backbones of the grounded theory. In fact, allowing participants their own agenda was a major strength of this grounded theory, as otherwise the relational nature of their processes would have remained hidden.

Second, smaller sample sizes yield the question of saturation. Corbin & Strauss (p. 139) have defined saturation as the point where “no new categories or themes are emerging”. Clearly, saturation was not reached due the projects time frame as a master’s thesis and the fact that the response rate to participate was fully exploited. Again, theoretical sampling did bring such a variety of new concepts, that finishing the project would not have been possible in a reasonable time frame. On the contrary, theoretical sampling allowed to take a broad overview on the possible motives and strategies of volunteers, and the circular process of data collection and analysis allowed for in depth-descriptions of the volunteers personal world.

Third, issues regarding the meaning of expression arise from translating the interviews from German to English. Analysis was conducted on the original German transcripts, whereas quotes were carefully translated by the author. Figurative speech and the use of dialect represented barriers to translation. Van Nes, Abma, Jonsson & Deeg (2010) have warned that translation between to language is itself an act of interpretation that can result in loss of meaning, especially when participants use words that are associated with specific cultural meaning. A strength of the study was the use of interactive member checking to counteract such phenomena; as results indicate that participants felt adequately understood, loss of meaning is less likely to have occurred.

Fourth, insider-research introduces an element of social desirability bias to the research situation. Interviewees might abstain from disclosing fully as a result of feeling evaluated by the researcher (see also reflexivity), although in practice, quite the opposite was observed: participants indeed felt eager to disclose about their work, and it seems that they felt their perspective to be appreciated – resulting in heightened disclosure.

Fifth, the use of a directive interview guide may lead to forcing the researchers own conceptual understanding onto the data. Even more so in constructivist grounded theory that denies the existence of an independent-objective reality in favor of co-construction, generation of theory depends on the reflexive abilities of the researcher, as “social patterns, organization, macro phenomena, social system aspects ... have no properties or emergent

characteristics distinct from situated social encounters” (Layder, 2019, p. 16). One strength of this study was the reservation of a dedicated free-space section in the interview schedule, where participants could freely express themselves without directive questions. However, further research is warranted clarify the semantic expressions by which hospice volunteers relate to positive resources outside co-constructed interview situations is warranted, possibly through ethnographic semantics (Maeder, 2002). In this way, the dangers of co-constructed knowledge generation could be prevented as the focus would like on in-group semantics themselves.

Implications for practice

Results of the study warrant recommendations to further improve mental health of hospice volunteers. While many volunteers already have extensive knowledge of personal strategies for keeping up their mental health, specific recommendations can be made.

First, organizations could encourage an open culture of feedback between the volunteer cohort and the administrative board. Feedback culture enables to volunteers to understand themselves as self-efficacious agents and perceiving oneself as self-efficacious was found to encourage positive self-evaluation and positive affect through external re-affirmation. At the same time, feedback culture heightens the perception of shared appreciation, bearing the potential to make use of it as a positive psychological resource in organizational practice.

Second, organizations could strengthen their offerings of interpersonal support by offering more supervision and coordinated group activities. Volunteers highly value these activities and clearly understand them as tools for coping with difficult situations. Therefore, their availability directly impacts the volunteer’s mental health in the long term.

Third, hospice organizations could provide educational resources about the helper’s syndrome. Helper’s syndrome is a highly present motivation in hospice volunteers, but it seems that some volunteers are unaware of its limitations and the fact that too much self-less helping can be intrusive to clients. Providing educational sessions, probably in the format of group discussions, can be used to heighten awareness.

Fourth, hospice organizations could provide training sessions on self-reflection of the volunteers own autobiographic history to account for the fact that volunteers are motivated to help by the resolution of their past and their experiences with death. Such self-reflection

would enhance the volunteers understanding about their motivations in the light of their personal learning journey.

Conclusion

Purpose of the study was to describe the relation between hospice volunteers' idiosyncratic experiences and their perception of mental health. The study added a procedural resource-oriented theory towards the maintenance and enhancement of hospice care volunteer's mental health through the exchange of appreciation as a positive resource and offered practical guidance for hospice organizations to implement this view in their daily operations by building an open feedback culture of interpersonal support, increased educational resources and opportunities for volunteer self-reflection. Common measurement instruments for volunteer motivation have focused on motivations prior to joining the organization but fall short to explain by which processes mental health is maintained long-term, signifying the need to enhance standardized quantitative measures by qualitative methods to account for procedural elements of interaction. In a time where the corona virus widely challenged the palliative doctrine of leaving no one to die alone, a heightened awareness about procedural exchange of positive resources can support hospice organizations in preserving and improving their volunteer's mental health so that they can continue doing their important work despite challenges.

- **Part 1 – Initial open questions**

- How old were you when you started volunteering in the hospice?
- Can you tell me about any precipitating events that led to or catalyzed your decision to start volunteering in a hospice?
 - What were your thoughts and feelings about starting to volunteer at that point in time?
 - Can you describe what kind of person you were at this point in time?
- Tell me about what happened to you when you started working with dying clients?
 - What positive changes did occur to you?
 - What negative changes did occur to you?
 - How did you change as a person as compared to the kind of person you were before starting the volunteer work?
 - What kind of consequences did you experience from working with dying clients have on your mental wellbeing?

- **Part 2 – Motives relating to personal gain (pseudo-altruism) ****

- Tell me what your motives were for starting to volunteer in a hospice organization?
- What would you say is your single most important motive?
- Did you notice changes in self-esteem or feelings about yourself as a result of helping?
(personal gain, enhancement)
- Did you experience any career related gains from doing volunteer work?
(career motives)
- Is the way other people experience you in your role as a volunteer important to you?
(social desirability, self-promotion)
- Can you describe how the experience of these motives influenced your mental wellbeing and feelings?

- **Part 3 – Motives relating to true altruism and values ****

- How does the volunteering correspond to the moral values you have?
 - Can you describe an instance of where you were able to act according to your values when working with a dying client?
 - What influenced your actions?
(values, civic responsibility)
- Can you describe how the experience of these motives influenced your mental wellbeing and feelings?

- **Part 4 – Theoretical sampling and open space**

- Questions that direct theoretical sampling (see Appendix A)
- *If applicable*: spontaneous questions to follow up on concepts brought up by the participant or to saturate concepts from previous interviews
- Is there anything else that you would like to express?
- Do you have any questions left for me?

** These questions probe deeper into the already known motives for hospice volunteering as described by the factor structure of IMHPCV and VFI; the relevant subscale is in brackets.

Appendix B: informed consent

Prosoziale Motivation und Mental Health bei Hospizfreiwilligen – eine Grounded Theory Perspektive

Einwilligung zur Teilnahme

Christian Schulz

Universiteit Twente

Faculty of Behavioral, Management and Social Sciences

Department of Psychology

Drienerlolaan 5

7522 NB Enschede

Niederlande

Hiermit erkläre ich meine freiwillige Teilnahme an der Interviewstudie „Prosoziale Motivation und Mental Health bei Hospizfreiwilligen – eine Grounded Theory Perspektive“.

Ich stimme explizit zu, dass der Ton des Interviews elektronisch aufgezeichnet, gespeichert und für Forschungszwecke ausgewertet wird.

Ich stimme zu, dass die Inhalte des Interviews in der Forschungsarbeit teilweise und/oder in Gänze zitiert werden. Dabei werden alle Namen, Orte und sonstige persönliche Daten, die Rückschlüsse auf meine Person und/oder meine Beziehungen zu Arbeitgebern und/oder Organisationen zulassen könnten, vor der Veröffentlichung anonymisiert.

Die Forschungsarbeit wird dauerhaft im öffentlichen elektronischen Archiv der Universität (<http://essay.utwente.nl>) veröffentlicht.

Meine Erlaubnis zur Verarbeitung des geführten Interviews kann ich innerhalb von zwei Wochen nach dem Interview jederzeit und ohne Angaben von Gründen widerrufen. In diesem Fall werden alle aufgezeichneten Daten zerstört und es entstehen keinerlei Nachteile für die Teilnehmer*innen.

Bei Fragen stehen wir Ihnen jederzeit gerne unter oben angegeben Kontaktdaten zur Verfügung.

() Ich wünsche eine Kopie der Abschlussarbeit per E-Mail.

Ort, Datum

Unterschrift Teilnehmer*in

References

- Birt, L., Scott, S., Cavers, D., Campbell, C., Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research, 26*(13), 1802-1811. doi:10.1177/1049732316654870
- Bohlmeijer, E., Westerhof, G. (2019). A new model for sustainable mental health, Integrating well-being into psychological treatment. In Kirby, J., Gilbert, P. (Ed.), *Making an Impact on Mental Health and Illness*. London: Routledge.
- Bowen, G. (2006). Grounded theory and sensitizing concepts. *International Journal of Qualitative Methods, 5*(3), 12-23. doi:10.1177/160940690600500304
- Brown, S., Nesse, R., Vinokur, A. (2003). Providing Social Support May Be More Beneficial Than Receiving It: Results From a Prospective Study of Mortality. *Psychological Science, 14*(4), 320-327. doi:10.1111/1467-9280.14461
- Burns, D., Reid, J., Toncar, M., Fawcett, J., Anderson, C. (2006). Motivations to volunteer: The role of altruism. *International Review on Public and Nonprofit Marketing, 3*, 79-91. doi:10.1007/BF02893621
- Burns, E., Fenwick, J., Schmied, V., Sheehan, A. (2012). Reflexivity in midwifery research: The insider/outsider debate. *Midwifery, 28*, 52-60. doi:10.1016/j.midw.2010.10.018
- Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. Thousand Oaks: SAGE.
- Clary, E., Snyder, M., Ridge, R., Copeland, J., Stukas, A., Haugen, J., Meine, P. (1998). Understanding and assessing the motivations of volunteers: A functional approach. *Journal of Personality and Social Psychology, 74*(6), 1516-1530. doi:10.1037//0022-3514.74.6.1516
- Claxton-Oldfield, J., Fawcett, C., Wasylikiw, L. (2004). Palliative Care Volunteers: Why Do They Do It? *Journal of Palliative Care, 20*(2), 78-84. doi:10.1177/082585970402000203
- Claxton-Oldfield, S., Claxton-Oldfield, J., Paulovic, S., Wasylikiw, L. (2012). A Study of the Motivations of British Hospice Volunteers. *American Journal of Hospice & Palliative medicine, 30*(6), 579-586. doi:10.1177/1049909112462057
- Claxton-Oldfield, S., Wasylikiw, L., Mark, M., Claxton-Oldfield, J. (2010). The Inventory of Motivations for Hospice Palliative Care Volunteerism: A Tool for Recruitment and Retention. *American Journal of Hospice & Palliative medicine, 28*(1), 35-43. doi:10.1177/1049909110373509

- Coar, L., Sim, J. (2006). Interviewing one's peers: methodological issues in a study of health professionals. *Scandinavian Journal of Primary Health Care*, 24(4), 251-256.
doi:10.1080/02813430601008479
- Corbin, J., Strauss, A. (2015). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (4 ed.). Thousand Oaks: SAGE.
- Deutscher Hospiz- und PalliativVerband e.V. (2017). Qualifizierte Vorbereitung ehrenamtlicher Mitarbeiterinnen und Mitarbeiter in der Hospizarbeit. Retrieved from https://www.dhpv.de/tl_files/public/Service/Broschueren/Broschüre_QualifizierteVorbereitung_Ansicht.pdf
- Dulin, P., Hill, R. (2003). Relationships between altruistic activity and positive and negative affect among low-income older adult service providers. *Aging & Mental Health*, 7(4), 294-299. doi:10.1080/1360786031000120697
- Dywer, S., Buckle, J. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods*, 8(1), 54-63.
doi:10.1177/160940690900800105
- Feigin, S., Owens, G., Goodyear-Smith, F. (2014). Theories of human altruism: a systematic review. *Annals of Neuroscience and Psychology*, 1(1), 1-9.
- Gerhard, C. (2015). Total-Pain-Modell *Praxiswissen Palliativmedizin*. Stuttgart: Thieme.
- Greenfield, E., Marks, N. (2004). Formal Volunteering as a Protective Factor for Older Adults' Psychological Well-Being. *The Journals of Gerontology: Series B*, 59(5), 258-264. doi:10.1093/geronb/59.5.s258
- Harris, A., Thoresen, C. (2005). Volunteering is Associated with Delayed Mortality in Older People: Analysis of the Longitudinal Study of Aging. *Journal of Health Psychology*, 10(6), 739-752. doi:10.1177/1359105305057310
- Heller, A., Pleschberg, S. (2015). Geschichte der Hospizbewegung in Deutschland. Hintergrundfolie für Forschung in Hospizarbeit und Palliative Care. In Schnell, M., Schulz, C., Heller, A., Dunger, C. (Ed.). *Palliative Care und Hospiz: eine Grounded Theory*. Wiesbaden: Springer.
- Kahana, E., Bhatta, T., Lovegreen, L., Kahana, B., Midlarsky, E. (2013). Altruism, Helping, and Volunteering: Pathways to Well-Being in Late Life. *Journal of Aging and Health*, 25(1), 159-187. doi:10.1177/0898264312469665
- Karnieli-Miller, O., Strier, R., Pessach, L. (2008). Power Relations in Qualitative Research. *Qualitative Health Research*, 19(2), 279-289. doi:10.1177/1049732308329306

- Keyes, C. (2002). The Mental Health Continuum: From Languishing to Flourishing in Life. *Journal of Health and Social Behavior*, 43(2), 207-222. doi:10.2307/3090197
- Keyes, C. (2005). Mental Illness and/or Mental Health? Investigating Axioms of the Complete State Model of Health. *Journal of Consulting and Clinical Psychology*, 73(3), 539-548. doi:10.1037/0022-006X.73.3.539
- Layder, D. (2019). The Limitations of Grounded Theory *Investigative Research: Theory and Practice* (pp. 61-86). Seven Oaks: SAGE.
- Maddux, J. (2009). Stopping the ‚madness‘: positive psychology and deconstructing the illness ideology and the DSM. In Lopez, S. J., Snyder, C. R. (Ed.), *Oxford handbook of positive psychology* (pp. 61-69). New York: Oxford University Press.
- Maeder, C. (2002). Everyday Routine, Social Structure and Sociological Theory: Using Ethnographic Semantics for Research on Prisons. *Fourm Qualitative Social Research*, 3(1). doi:10.17169/fqs-3.1.879
- Oxford Advanced American Dictionary. (n.d.). Definition of appreciation (noun). Retrieved from https://www.oxfordlearnersdictionaries.com/definition/american_english/appreciation
- Parsons, T. (1976). *Zur Theorie sozialer Systeme*: VS Verlag für Sozialwissenschaften.
- Planalp, S., Trost, M. (2009). Motivations of Hospice Volunteers. *American Journal of Hospice & Palliative medicine*, 26(3), 188-192. doi:10.1177/1049909108330030
- Post, S. (2005). Altruism, Happiness, and Health: It's Good to Be Good. *International Journal of Behavioral Medicine*, 12(2), 66-77. doi:10.1207/s15327558ijbm1202_4
- Raheim, M., Magnussen, L., Sekse, R., Lunde, A., Jacobsen, T., Blystad, A. (2016). Researcher-researched relationship in qualitative research: shifts in positions and researcher vulnerability. *International Journal of Qualitative Studies on Health and Well-being*, 11(30996). doi:10.3402/qhw.v11.30996
- Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, 57(6), 1069-1081. doi:10.1037/0022-3514.57.6.1069
- Schwartz, C., Meisenhelder, J., Ma, Y., Reed, G. (2003). Altruistic Social Interest Behaviors Are Associated With Better Mental Health. *Psychosomatic Medicine*, 65(5), 778-785. doi:10.1097/01.psy.0000079378.39062.d4
- Stegmaier, P. (2020). *Grounded Theory for Beginners*. Dortmunder Methoden Workshop.
- Stelzer, E., Lang, F., Hörl, M., Kamin, S., Claxton-Oldfield, S. (2018). German Version of the Inventory of Motivations for Hospice Palliative Care Volunteerism: Are There Gender

- Differences? *American Journal of Hospice & Palliative medicine*, 35(2), 304-315.
doi:10.1177/1049909117706958
- Van Nes, F., Abma, T., Jonsson, H., Deeg, D. (2010). Language differences in qualitative research: is meaning lost in translation? *European Journal of Ageing*, 7(4).
doi:10.1007/s10433-010-0168-y
- Watts, J. (2012). The place of volunteering in palliative care. In E. Chang, Johnson, A. (Ed.), *Contemporary and Innovative Practice in Palliative Care* (pp. 83-102): InTech.
- Wood, A., Froh, J., Geraghty, A. (2010). Gratitude and well-being: a review and theoretical integration. *Clinical Psychology Review*, 30(2010), 890-905.
doi:10.1016/j.cpr.2010.03.005
- World Health Organization. WHO Definition of Palliative Care. Retrieved from <https://www.who.int/cancer/palliative/definition/en/>
- World Health Organization. (2018). Mental health: strengthening our response. Retrieved from <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>