When the Road is Rocky:

Investigating the Role of Vulnerability in Consumer Journeys

Abstract

Journey research has primarily analyzed agentic, solo travelers making rational single-purchase decisions. In contrast, we examine a journey where consumers and their traveling companions are vulnerable and must navigate an unfamiliar service system. We explore how vulnerability shapes consumer journeys, how service and system factors impact vulnerability, and how traveling companions influence agency and vulnerability. Using data from an extensive study into end-of-life care, our results reveal novel insights into the role of consumer vulnerability throughout a journey. We show how the ebb and flow of consumer vulnerability shapes the journey, and how the journey shapes vulnerability. Traveling companions, themselves vulnerable, play a major role in influencing vulnerability and the journey itself. We offer managerial implications for organizations whose consumers are in vulnerable situations.

Keywords: Consumer journeys, Vulnerable consumers, Consumer experience, Customer journeys, Complex service systems, Traveling companions.

Consumers embark on multiple journeys to seek solutions to various goals. During these journeys they encounter touchpoints (i.e., tangible, and intangible interactions) that impact their experiences (Zomerdijk and Voss 2010). Research into journeys has flourished recently (Tueanrat et al. 2021), and provides holistic insights into problems, needs, and motivations. Most customer journey research is rooted in path-to-purchase models (Lemon and Verhoef 2016) and depicts consumers as agentic, rational decision-makers who make optimal, informed choices. Yet sometimes consumers experience vulnerability, which is an undesirable state arising from conditions and contexts (Hamilton et al. 2016). Within the domain of consumer journey research, we specifically examine the role of consumer vulnerability.

Vulnerability is marked by the absence of, or diminished capacity for, agency (Hill and Sharma 2020). Agency refers to intentional activity: exerting power, being in control, and making things happen. When a person lacks agency, they are vulnerable. Actions to regain agency are attempts to reduce vulnerability (Hewson 2010). Vulnerability can arise from four situations (Baker et al. 2016; Pavia and Mason 2014). First, vulnerability can stem from biophysical or psychosocial factors such as disability or age. Second, vulnerability can spillover from biophysically vulnerable people to those in their social network. An example of secondary vulnerability is a person with dementia whose needs and vulnerability spillover to their caregivers and negatively impacts the caregiver's resources, autonomy, and wellbeing (Sandberg et al. 2022). Third, vulnerability can relate to environmental consequences, e.g., in the aftermath of a disaster such as a flood or a house fire. Finally, vulnerability can pertain to marketplace powerlessness (Baker et al. 2005), arising from a lack of perceived control or disorientation within a particular consumption situation. Our journey setting is hospice and end-of-life care (EOLC). Hence, we explore the journeys of people who are already vulnerable (from the biophysical perspective), and their caregivers (who may be secondary vulnerable)

and examine how their vulnerability is impacted throughout their journeys due to the nature of the services they require and the systems they must navigate.

When consumers are vulnerable, they often require negative services (Morgan and Rao 2006), which exist to fix people (e.g., healthcare, addiction) and/or things (e.g., serious automobile collisions). Negative services are central to many facets of health, social care, wellbeing, public security, and law, yet are rarely the focus of marketing research (Spanjol et al. 2015). Negative services transcend not being wanted: they deal with non-routine problems that arise from catastrophe and are perceived as risky, invasive, and/or psychologically stressful (Berry and Bendapudi 2007). The nature of negative services also restricts consumer choice (Morgan and Rao 2006). Hence, just needing a negative service reduces consumer agency. EOLC offers an appropriate study setting because the clinical EOLC literature verifies these factors among EOLC patients and their families. A terminal diagnosis is catastrophic and results in heightened fear, stress, and uncertainty, while decision-making at end-of-life is particularly difficult and marked by restricted choice (Sleeman et al. 2021).

Most negative services are highly complex, involving multiple providers and networks (Morgan and Rao 2006). Journeys requiring consumers to navigate numerous providers differ from those encompassing single organizations. Yet, prior journey research does not often reflect this complexity (Lemon and Verhoef 2016). We address this oversight by using a complex adaptive systems (CAS) lens to examine a journey through a dynamic service system comprising multiple sub-systems and diverse agents interacting in different networks (Ellis et al. 2017). Our setting is the United Kingdom (UK), where delivery of EOLC is highly fragmented and provided by multiple organizations including the National Health Service (NHS), private, voluntary, and community sectors.

Consumer journeys through complex systems are rarely traveled alone (Hamilton et al. 2021). Yet, due to its almost exclusive concentration on solo consumers (Thomas et al. 2020),

the extant journey literature has until recently neglected to consider the prevalence of social journeys and the influences of traveling companions (Hamilton 2021). Within the EOLC context, family caregivers have multifaceted roles. In addition to their increasingly important role as providers of practical and emotional care (Hospice UK 2022), they receive support from EOLC services before and after bereavement, effectively making them secondary consumers. Family caregivers play a central part in decision-making at the end of life (Sleeman et al. 2021). Finally, they are exposed to secondary vulnerability. Our inclusion of caregivers as 'traveling companions' therefore provides empirical insights into the ways companions influence and are influenced by journeys taken by vulnerable consumers.

Our journey study enables us to take a more holistic perspective than do path-to-purchase journey models. Some research takes a "jobs to be done" approach (Epp and Price 2011), where a "consumer job journey" is synergistic and comprises multiple journeys where goals transcend consumption situations (Bettencourt et al. 2022). Hamilton and Price (2019) suggest labeling such journeys *consumer* rather than *customer* journeys to differentiate journeys that are motivated by more abstract goals and incorporate roles beyond that of a customer from those with a precise consumption goal. Because consumer journeys usually entail navigating multiple providers, they require a more holistic understanding of the consumer experience to avoid a myopic concentration on a single provider. Consumer journey research should include "a narrative of a progression in which overcoming fear and failure may be important parts" (Hamilton and Price 2019, p.188). The journey through EOLC, therefore, meets the criteria for a consumer journey.

Summarizing, we focus on the role of vulnerability in consumer journeys, using the context of EOLC. We analyze consumer journeys through negative services delivered by complex systems that involve traveling companions. These factors are particularly important in the context of vulnerability. Our broad aim is to examine vulnerability throughout an accompanied

consumer journey that requires navigating a negative and complex service. Based on our definition of vulnerability as the absence of, or diminished capacity for, agency, we explore the following questions: (1) How does vulnerability shape a consumer journey? (2) How do service and system factors impact vulnerability during the journey? (3) How do traveling companions influence agency and feelings of vulnerability? We acknowledge our case is an extreme journey. People experiencing EOLC are exceptionally vulnerable, and their caregivers may also experience secondary vulnerability. Vulnerability is exacerbated by grief (Baker et al. 2005). EOLC does not have a way back to restore the consumer's equilibrium, unlike healthcare journeys that focus on cure, or those that help overcome homelessness or addiction. Facing a journey through a negative service delivered within an unfamiliar and complex system may compound vulnerability further. EOLC in the UK is highly fragmented, making it a particularly complex service system. Finally, family caregivers are especially important in the EOLC journey, having multiple roles as providers, secondary consumers, and decision-makers. This extreme context provides insights into vulnerability that have hitherto been overlooked in journey research.

Our results show that the situation that kick-starts this type of journey leads to an overwhelming sense of confusion and, in keeping with the journey metaphor, a sense of having lost one's way and being unsure where to turn from the outset. Service and system touchpoints initially exacerbate this situation, causing further vulnerability, which leads to ambivalence and journey delays. This liminal period is marked by fear of role loss. Throughout the journey, vulnerability ebbs and flows as consumers struggle to understand their situation. We find traveling companions act as project managers that eventually find ways to overcome the many constraints to journey navigation, and finally, at the journeys end, a reduction in vulnerability as some agency is restored. We widen journey knowledge by contributing to our understanding of consumer journeys as they relate to lived experiences (Akaka and Schau 2019).

Theoretical Foundations

A review of the recent journey literature reveals an expanding body of scholarship with many theoretically insightful and managerially practical contributions. Numerous papers are conceptual. Via an extensive literature search, we identified 25 papers that focus on empirical customer or consumer journeys and are (a) published in high-ranking journals, and/or (b) cited either extensively in the literature, and/or (c) authored by respected scholars in this field. These papers are presented in Table 1.

Insert Table 1 approximately here.

Many journeys transcend consumption-related goals. Indeed, a consumer journey may not have clearly defined or understood goals, and implicit goals may change during the journey (Hamilton and Price 2019). Such journeys often necessitate multiple-consumption situations as well as non-consumption inputs (Bettencourt et al. 2022). Hence, consumer resources and agency matter (Kranzbühler et al. 2018). In these situations, the *customer* journey falls short because its focus is limited to someone interacting with a firm who wishes to solve a consumption-related problem. A *consumer* journey has much broader connotations, having goals, however abstract, that are non-consumption related, and roles that transcend those of a customer (Hamilton and Price 2019). In consumer journeys, key touchpoints are perceived to be important from the consumer's, rather than the firm's, perspective (Becker and Jaakkola 2020). The cognitive, emotional, and behavioral impact of different touchpoints on consumers are also key considerations (Hollebeek et al. 2023). In such cases, the research spotlight expands and the focus shifts to the journey itself (Hamilton and Price 2019).

We found only five studies that can be classified as consumer journeys (column labeled *consumer* in Table 1). All examine extraordinary experiences. In their study of surfing practices, Akaka and Schau (2019) reveal how reflexivity shapes a consumer's identity through interactions with multiple institutions. Identity is also a central theme in Gyimóthy's (2000)

study of tourism dyads, where she illustrates how hedonic experiences enable consumers to enact roles beyond that of a customer and those encountered in their everyday lives. Travelers, this time student sojourners temporarily residing in America, are the focus of Vredeveld and Coulter's (2019) work. Rather than self-identity, however, they examine how consumers seek authentic cultural experiential goals. The two remaining consumer journey studies concentrate on challenging and often grueling journeys when consumers are also patients. Nakata et al. (2019) focus on medication compliance among patients with chronic hypertension, while Trujillo Torres and DeBerry Spence (2019) identify ways in which consumers valorize (i.e., assign value) during traumatic cancer journeys.

Table 1 also illustrates which empirical work incorporates vulnerable consumers (*vulnerable*); those journeys requiring a negative service (*negative*); journeys that entail multiple rather than single providers (*complex*); and those accompanied by traveling companions (*social*). While these core areas are interrelated, we now focus on each of them in detail. We show how the field still lacks knowledge of (a) how vulnerability shapes consumer journeys; (b) how negative service touchpoints impact consumer vulnerability; (c) how complex systems impact consumer vulnerability and journey progress; and (d) how traveling companions experience vulnerability and influence the journey.

Consumer Vulnerability

Agency is central when considering consumer vulnerability since consumers may perceive themselves to be vulnerable when agency is absent or reduced. Key considerations are risk, dependency, power, choice, and control (Hewson 2010). Three findings are noteworthy in this context. First, vulnerability is related to self-perception. For example, a disabled consumer is not automatically vulnerable if they consider themselves in control of their consumption situation. Second, vulnerability is related to the interplay between the consumer and the marketplace: vulnerability can arise from a power imbalance where marketplace factors may

render consumers vulnerable. Third, vulnerability is important to study from a consumer journey perspective because everyone can feel vulnerable in certain contexts (Baker et al. 2005). Anxiety caused by the trigger that kickstarted the journey can lead to a transformation where consumers become less agentic and self-assured and more helpless and dependent (Berry and Bendapudi 2007). Already lacking agency, consumers often then need to navigate a negative service that is unfamiliar and usually complex. A lack of experience and knowledge on the part of the consumer means the balance of power lies with service providers. Whether journey navigation compounds or alleviates vulnerability will depend partly on the touchpoints controlled by the provider organizations.

Empirical inquiries into consumer vulnerability beyond disadvantaged groups based on their biophysical or psychosocial status are relatively rare. Notable and relevant exceptions include a sense of helplessness among carers in the tourism marketplace (Hunter-Jones 2010), trade-offs between autonomy and security in nursing home servicescapes (Sandberg et al. 2022), and some important work into health (Mason and Pavia 2016) and bereavement-induced vulnerability (Turley and O'Donohoe 2017). However, none of these examine vulnerability from a journey perspective. Of the three empirical journey studies identified in Table 1 that do deal with vulnerable consumers, Trujillo Torres and DeBerry-Spence (2019) focus on valorization and the ways in which consumers find agency, suggesting that it is possible that consumers find ways of overcoming vulnerability during difficult journeys, as we ask in our first research question. Of the remaining two studies, Nakata et al. (2019) report one instance of a consumer being made to feel more vulnerable after a difficult service encounter, while Crosier and Handford (2012) remind us that consumer journeys should be mapped across the whole customer experience rather than with single firms, as the linkages can exacerbate vulnerabilities for disabled consumers. Undoubtedly, these studies suggest that service factors can impact vulnerability, and all underscore the need to redress journey research limitations

based on agentic consumers. However, knowledge of how contextual vulnerability shapes consumer journeys, and insights into the ways in which traveling companions influence agency and vulnerability are still lacking.

Negative Services

Morgan and Rao (2006) differentiate positive (hedonic), neutral (utilitarian), and negative services. Negative services have three characteristics: they are not routine, they exist to fix people or things, and they deal with problems most people hope they will never have to deal with. Importantly, not all unwanted services can be classified as negative. For example, needed but unwanted services such as those provided by dentists, plumbers, or mechanics are routine when consumers are largely in control of the purchase situation (Morgan and Rao 2006). We therefore define a negative service as one where consumer agency is restricted and need is triggered by an unusual, unwelcome, and often catastrophic event. Examples include those that exist to deal with serious physical or mental health issues, homelessness, addiction, refugees, contested divorces, and severe road accidents. Such events make people anxious, which is a physiological response to feeling vulnerable (Pillay 2014).

These key differences between negative and other services are important because marketplace factors can increase vulnerability (Baker et al. 2005). The nature of negative services may also impact the consumer's journey. Lemon and Verhoef (2016) stress two issues that are relevant here. First, researchers should consider how past experiences influence current journey experiences. However, the need for a negative service is relatively rare, so consumers may have no previous experience from which to draw, which likely increases their vulnerability. Second, context matters, and the broader service delivery system is a critical consideration. Yet, as Table 1 illustrates, most journey insights arise from studies of neutral purchases (e.g., motor insurance, telecom services) or the pursuit of positive experiences (e.g., tourism, entertainment). We only identified two studies focusing on negative services: those

same two identified earlier where consumers are also patients. Nakata et al. (2019) emphasize the importance of context and show that consumer journeys need to be explored as situated and extended experiences, rather than from the standard path-to-purchase model. They support Trujillo Torres and DeBerry-Spence's (2019) assertion that context is crucial, especially in traumatic journeys. These two innovative and rare studies undoubtedly provide some important theoretical contributions to consumer journey knowledge, and show that even during extremely difficult journeys, consumers can find agency. However, what remains unclear is how service-related touchpoints specifically impact consumer vulnerability and help or hinder journey progress. Nor do we know anything about the influence of traveling companions on journeys.

Complex Service Systems

Negative services are usually delivered by networks of service providers rather than single firms (Morgan and Rao 2006). Thus, journeys entailing negative services are likely to incorporate multiple touchpoints under the control of various organizations (Becker and Jaakkola 2020). Many negative services are therefore nested within complex service systems. Our definition of a complex service system comes from complex adaptive systems (CAS) theory, which views complex systems as multiple sub-systems of diverse agents interacting and self-organizing. Complexity relates to the dynamic nature of interconnections and how internalized institutional logics shape their behavior, from which new self-organizing behaviors emerge (Ellis et al. 2017). CAS has much in common with a service ecosystem perspective (Vargo et al. 2023), and a service ecosystem borrows key elements from CAS. However, we use CAS for our purposes because it focuses on complexity rather than value cocreation.

Three relevant elements of CAS are agents, interconnections, and self-organization. Agents are individuals and organizations. CAS recognizes agent diversity and acknowledges that agents have different information from each other, with none understanding the entire system.

Diversity and imperfect knowledge add to complexity (Ellis et al. 2017). The essence of CAS is captured in the interconnections between agents: how nonlinear interconnections occur at multiple levels, and how the richness of interconnections, particularly at a local level, can influence each other, often leading to complex local rules and behaviors (Ellis and Herbert 2011). Self-organization emerges when agents attempt to achieve order within this complexity. Agents draw on their core institutional logics, which are sets of practices, values, assumptions, and beliefs that guide behavior. Agents have different institutional logics, and even within the same organization multiple logics emerge and often conflict (Kurtmollaiev et al. 2018), leading to contradictory expectations among stakeholders within and outside the organization. Well-documented problems in complex systems relate to communication, coordination, and inter-collaboration (Ellis et al. 2017). However, how these problems impact consumer vulnerability within a consumer journey is unknown.

CAS views interactions between agents and system elements as unstable, and instability often lies within interactions and interdependencies (Ellis and Herbert 2011). Empirical work shows how CAS, by embracing the 'messiness' inherent in complex systems, can improve network performance, aid change management, enhance providers' reactions to uncertainty, and improve service (Khan et al. 2018). Analysis based on noncomplex assumptions, such as dyadic relationships, risks allowing problems to remain hidden. Just as conventional conceptualizations of service as dyadic collaborations are inadequate because they fail to capture the dynamic multidimensional nature of today's complex services (Vargo et al. 2023), journey analyses that focus on a single provider risk missing important elements of the multifaceted consumer experience (Epp and Price 2011). However, most studies in Table 1 focus on a single provider. Some attention has been paid to multichannel choices and omnichannel management, analyzing spillover and carryover effects (Anderl et al. 2016) and the significance of showrooming (Hu and Tracogna 2020). In this context, the focus is on

agents, brokers, and affiliates in omnichannel management (Barwitz and Maas 2018; Li and Kannan 2014). Some studies acknowledge multiple providers (e.g., Crosier and Handford 2012), and others recognize that cultural and identity journeys encompass diverse brands (Akaka and Schau 2019; Gyimóthy 2000; Vredeveld and Coulter 2019). The literature also provides valuable insights into outsourcing some touchpoints, though the emphasis is still on the focal brand's management (Kranzbühler et al. 2019). What is missing is an examination of how diverse agents and their interconnections impact consumer vulnerability and help or hinder journey progress as consumers attempt to navigate this complexity.

Social Journeys

De Keyser et al. (2020) observed that although consumer experience is inherently social, literature is dominated by individual experiences. If the social context is mentioned, it is usually concerning social rules and norms, as though actual consumer experiences happen in a vacuum. This situation is reflected in the consumer journey literature. Recent conceptual work draws attention to this omission. Thomas et al. (2020) underscore the fact that most consumer journeys are experienced as a collective, be they pleasurable (e.g., vacations and eating out), routine (e.g., purchases for the home), or difficult (e.g., serious health crises). Hamilton et al.'s (2021, p.69) recognition that most journey models are "fundamentally decontextualized from social influences" led them to conceptualize the notion of the traveling companion, defined as social others interacting with the primary customer along the journey. Traveling companions influence the journey, and, in turn, are influenced, at any or all parts. Traveling together creates a joint journey that is complex and distinct from the solo journeys inherent in most journey research (Thomas et al. 2020).

Recent pleas for journey research to consider collectives (Hamilton et al. 2021; Thomas et al. 2020) mirror an appeal from Epp and Price (2011) a decade earlier, who called for consideration of shared goals to map the entire consumer experience. Yet, despite this long-

standing recognition, most studies in Table 1 concentrate exclusively on solo travelers, even when journeys are inherently social, such as hospitality experiences (Li and Kannan 2014). Stein and Ramaseshan (2016) find that interactions with others are key touchpoints in experience journeys. Akaka and Schau (2019, p. 502) point out that practice engagement with surfing is "social and collective". Yet, we can identify only three pieces of research in Table 1 that delve beyond the solo consumer. Gyimóthy (2000) interviewed pairs of travelers, thus recognizing the centrality of social experiences. Nakata et al. (2019) and Trujillo Torres and DeBerry-Spence (2019) underscore the importance of context and social support as additional factors in medication compliance and cancer journeys. However, none explicitly addresses a social journey traveled with a companion or considers how companions impact consumer vulnerability. Including family caregivers enables us to examine the wider implications of traveling companions and provides a unique opportunity to study secondary vulnerability, a type of consumer vulnerability often overlooked in literature and practice (Pavia and Mason 2014).

Methodology

Context: End-of-Life Care in the UK

EOLC is a particularly fitting setting for studying vulnerability within consumer journeys. Consumers are already vulnerable from a biophysical perspective, while their caregivers may be secondary vulnerable. EOLC is an extreme type of negative service, and our UK context is particularly complex, involving primary care providers (e.g., General Practitioners (GPs) and community nurses), secondary care providers (e.g., hospital EOLC), and tertiary care providers (e.g., autonomous hospices and hospice@home services). Points of delivery comprise multiple settings (e.g., patient's homes, care homes, and hospice units), often for the same patient. Diverse individual care providers within these organizations are classified as general healthcare professionals (e.g., GPs and community nurses) and specialist palliative care (SPC) providers

(e.g., hospice nurses). Finally, family caregivers are particularly suitable to study from a traveling companion perspective because they provide support to primary consumers, aid decision making, and are themselves users of EOLC services. According to the NHS (2023) the journey through EOLC services should be one that helps people to live as well as possible until death by receiving high quality care, for their choices to be respected, and for people to be helped to die with dignity.

Data Collection

This study is part of a larger research project investigating EOLC services in the UK, involving various data collection methods for over eight years. Our analysis draws primarily on collaborations with nine organizations providing EOLC. Table WebA1 in the Web Appendix details these organizations. Mapping the journey from a firm's perspective limits deep insights into multifaceted consumer experiences. Recent scholarship has attempted to redress this by mapping journeys from the consumer's perspective (Nakata et al. 2019). We transcend both perspectives and take a novel approach that incorporates multiple actors. Tables WebA2 to WebA4 in the Web Appendix detail our samples, which comprise primary consumers (n=88), traveling companions (n=169), and various provider agents from within (n=44) and outside (n=22) the focal organizations. Web Appendix Table WebA5 maps our research questions against the data utilized.

Primary Consumers and Traveling Companions. We used a method of storytelling called pathographies to collect journey experiences from consumers and companions. Pathographies are narratives of illness. Told in the first person, they incorporate holistic experiences, and give a voice and agency to the storyteller. Importantly from a journey perspective, pathographies comprise narratives of experiences of key touchpoints, and thus have the potential to understand a consumer's lived experience of institutional practices. We used the trajectory touchpoint technique (TTT) (Sudbury-Riley et al. 2020) to aid pathographies. The TTT

comprises sets of potential touchpoints, starting with perceptions from diagnosis before referral to EOLC, through to the present day. The final set, used only with the bereaved, comprises issues around experiences of death and bereavement. The TTT presents each potential touchpoint as a cartoon image, overcoming the need for direct questioning about taboo issues. The touchpoint images act as an aide memoir, and participants can talk about some, all, or none of them. TTT images transcend firm-controlled touchpoints, and incorporate cognitive, emotional, physical, sensory, and social elements of a consumer's journey experience (De Keyser et al. 2015).

Participants chose their place to narrate their pathographies. Inpatients chose their bedside or family rooms. Current caregivers chose rooms within hospice units or requested the research team visit them at home. Hospice@Home patients, their families, and many bereaved caregivers also opted to tell their stories in their own homes. On average, journey narratives lasted 25 minutes with patients and 45 minutes with their caregivers, although several exceeded two hours. Stories were audio-recorded and then transcribed verbatim.

Provider Agents. Limiting journey research solely to consumers overlooks the dynamics embedded in service systems (Hollebeek et al. 2023), and insights into non-consumer perspectives are important for marketing strategy development (Hamilton 2016). Hence, we interviewed two groups of providers. The first comprised a range of senior staff (n=44) from our participating organizations (Web Appendix Table WebA3) which provided further insights into firm-owned touchpoints. The second comprised semi-structured interviews with 22 frontline EOLC staff outside our focal organizations (Web Appendix Table WebA4). All had provided EOLC services in the previous six months. These interviews provided comprehensions into touchpoints beyond the control of the focal firms. These interviews were also audio recorded and transcribed verbatim.

Data analysis

Data analysis was an iterative process conducted by three of the authors. We used Spiggle's (1994) terminology and procedures. First, working independently, the three authors examined and categorized all the pathography and interview data for instances where vulnerability shaped a journey's progress. We did this without a priori codes or categories. Stage two was abstraction, which comprised sharing categories and collapsing them into conceptual constructs. During this stage we considered the instances identified in stage 1 concerning the different foci of our literature review (i.e., consumer vulnerability, negative service, complex system, and traveling companions). Key (from the consumer's perspective) and theoretically relevant (from the literature) constructs emerged. In the last stage, dimensionalization, we identified specific attributes inherent in our constructs, examining and defining relationships. Cognizant of our research questions, we grouped these into instances where primary or secondary vulnerability shaped the journey (research question 1), service and system factors that increased or decreased consumer vulnerability (research question 2), and the ways traveling companions influenced agency, therefore reducing vulnerability, and impacting the journey (research question 3).

Results

We found numerous and varied touchpoints that greatly impacted vulnerability. In keeping with the spirit of consumer journeys, we focus on cognitive, emotional, and behavioral issues that were perceived as key from the consumer's perspective rather than the firm's perspective (Becker and Jaakkola 2020). We examine those issues that impacted consumer vulnerability, how agency was reclaimed, and consider how these influenced the journey.

Research Question 1: How does vulnerability shape a consumer journey?

We find that vulnerability slows a consumer journey, initially through inertia and then through liminality. In early parts of the journey, consumer vulnerability results in severe inertia for both

consumers and traveling companions. We identified three vulnerability-related reasons: stress responses, cognitive vulnerability, and identity threats.

Stress responses. Stress responses are typically negative emotions induced by feelings of vulnerability (Gross 2015). Common emotions dominating early journey experiences were helplessness, shock, dependency, fear, and sorrow. Sylvia's reaction, recalled by her husband Tom, was typical:

"Never, in the 44 years we were married, had I seen her break down like that. She just went to bits. That is the only time" [Tom, patient's husband].

Such reactions, widespread among consumers, were also typical among companions:

"I'm a relatively eloquent person who can stand my ground, I'm not intimidated by anybody; but it's a terrible situation to be in, and there are times you don't know which way to turn [Eric, patient's husband].

These quotes illustrate how people, who were previously self-controlled, agentic individuals, were rendered vulnerable by the news that kick-started their journey. Coping is how a person deals with stress and has behavioral consequences. People can either act in a particular way, or not, in which case the individual can withdraw (Gross 2015). Sylvia's 'going to bits' and Eric's 'not knowing which way to turn' illustrate a *lack* of coping. We detected widespread *inaction* at the start of the journey, from consumers and companions, sometimes leading to regret:

"I could never work out if he knew. I did the paperwork, so I knew [death was imminent] but I was never completely sure if he knew. We never really had a proper conversation about the fact that he was dying. Sometimes, I wish we could have been a little more honest with each other. I think I was trying to hide things from him as I didn't want to distress him, and perhaps he was doing the same thing" [Pru, bereaved wife].

While Pru's situation is an example of continuing inaction, it can also be viewed as a form of extrinsic emotional regulation (Gross 2015), a strategy used by people attempting to regulate the emotions of others. Extrinsic emotional regulation can be seen as a form of control. However, in this case, it was done entirely for her husband's benefit, to avoid further distressing him. If Pru's suspicions are correct, and her husband was doing the same, we have an example of mutual extrinsic emotional regulation. The goal was to avoid further distress but negatively

impacted Pru later in her journey. We found emotional stress responses dominated early in journeys.

Cognitive vulnerability. Heightened stress can lead to cognitive vulnerability, which is a person's inability to understand facts and the impact of their situation on their lifeworld (Boldt 2019). Yvonne's helplessness is clear in the following quote:

> *"I just don't know what I should be like. My husband is dying. But do other people feel like that, or is it just me? I just want someone to say, 'oh yeah, you do feel like that,' or 'no, you are mad, you can't wait to get rid of him,' you know. Just to see if I am normal"* [Yvonne, patient's wife].

Yvonne's quote illustrates how her bewilderment with her lifeworld situation rendered her so vulnerable she doubted if she was normal. For many, the problem that required the journey was so overwhelming that a disabling 'brain-fog' set in where people could not fully comprehend information,

"You're in shock, and you don't hear half of what they tell you anyway" [Alan, patient];
"We were given some leaflets as well… I binned them" [Lisa, parent].

We found cognitive vulnerability accompanied elevated stress responses:

"It was just me and the doctor. The only things I heard were 'lung cancer' and 'we can't operate'. Three days! For three days I was trying to digest what she had said, trying to get my head around it. Everything else just went out of my head. It was just 'Lung cancer. We can't operate'" [Jason, patient].

Jason's experience is a clear example of cognitive vulnerability producing a disabling, fear-induced 'brain fog', which we found typical. The encounter between Jason and doctor undoubtedly comprised more than the five words, 'Lung cancer. We can't operate', but he could not comprehend this because of the emotive situation in which he found himself. Information needs are especially important in situations far from routine and where consumers have no prior experience. But cognitive vulnerability means consumers take in *less* information than they would normally, which leads to heightened vulnerability in the form of a knowledge disadvantage. The vicious cycle of vulnerability continues because knowledge disadvantages further hamper decision-making (Pillay 2014). The reference to 'we can't operate' in Jason's

story implies that he must try to come to terms with this impact on his lifeworld. Such serious contemplation takes time: influencing the speed at which he begins to consider any help that may be available.

Some participants recognized their need for information, but cognitive vulnerability clouded their ability to understand basic marking communications, as Avril recalls:

> *"It's very difficult when you read the leaflet to interpret it. You are in an alien set of circumstances, you don't get training for this, it isn't a mainstream activity in your life, you hear about someone up in the hospice, you picture it in your mind, but intellectually you don't go there, and suddenly you are faced with the enormity of it*" [Avril, bereaved].

Others were unable to fully comprehend the oral information they had received:

"It's confusing because the initial diagnosis wasn't really a diagnosis. It was just the GP telling us he thinks it's secondary cancer. So, we really didn't know what to do with that information. We just came home, and we were a bit numb. And because it wasn't an official diagnosis…you put it to the back of your mind" [Doris, patient's wife].

Whether caused by the shock of an unexpected diagnosis, or confusion due to a vague diagnosis, a sense of numbness was obvious for all at the start. The strategy of 'putting it to the back of your mind' that Doris refers to was typical, resulting in limbo where many did nothing. Typically slowing down the journey at outset, many later regretted their early inaction:

> *"I wish we'd done it sooner… we just didn't know what to expect"*
> [Liz, patient's wife].

Others attempted to initiate a coping strategy called situation modification (Gross 2015), which entails taking action to modify the intensity of the emotional impact:

> *"You are trawling about trying to find out how you can help, and from the carers point how you can get some help, and how can my wife get information and help that will help us through this. The danger is you are vulnerable and so you tend to be more careful than perhaps you would if you were dealing with, say, oh this is a good car. You're worried you will get the wrong end of the stick" [Bill, patient's husband].*

Bill's attempt to modify the situation was to regain some agency through amassing information he perceived would lessen the vulnerability he explicitly mentions. It is also an example of how many attempts to regain agency failed at the beginning of the journey, backfiring, and further increasing feelings of vulnerability, which led to further journey delays.

Identity threats. Trigger events that lead to vulnerability are often caused by unanticipated external factors (Commuri and Ekici 2008), leading to demands on consumers to take on new roles. We found much identity-related resistance, which took two forms: fear of a new role, and dread of role loss. Many traveling companions felt unprepared for their new caregiver role:

"We're…we're not…you know, my brother and I, we're not nurses, are we? We didn't know what…what was around the corner. We didn't know what was expected of us. We haven't ever dealt with anything like this" [Sue, caregiver].

Vulnerability can arise when external situations demand new roles that the consumer is intrinsically unprepared for (Schewe and Balazs 1992). Anxiety is prevalent throughout Sue's quote. She is unprepared (not knowing what is around the corner), the role expectations are unfamiliar, and she has no normative guidance (not having ever dealt with anything like this). She perceives the role demands as daunting (she is not a nurse, and neither is her brother) and associates them with things only a professional could perform. Hence the vicious cycle of vulnerability continues as people begin to realize that this situation demands that they transition to a new role and status they do not want.

Vulnerability resulting from fear of relinquishing one's current role was also obvious in many narratives. Traveling companions feared their looming new identity as bereaved people, many dreading the transition from spouse to widow, afraid of the adjustments this new role would entail. Fear of role loss was most pervasive among the parents in our study:

"I wasn't really overly confident about him going to anybody else. Letting go was not a thing for me. He's my child! He's not anyone else's child" [Savanna, mother].

Savanna's quote clearly articulates prevalent tensions when parents must outsource care. Our findings support earlier work into the stress that accompanies such decisions (Epp and Velagaleti 2014). Savanna's story, however, goes beyond a reluctance to relinquish care. It lays bare her fear of losing her role as a mother (he's my child). Role loss negatively affects an individual's coping resources (Elwell and Maltbie-Crannell 1981). Identity transitions imposed on traveling companions by these journeys results in secondary vulnerability not solely due to

caring for a biophysically vulnerable person, but because of the identity transitions the journey enforces.

Identity transitions had a profound impact on the shape of consumer journeys. As people realized the significant impact of role changes, the initial inertia moved to disorientation due to unwelcome role-related demands. Agency was further compromised, and vulnerability was still pervasive. We identified this journey point as a disconnection between people's previous lives and the start of their new life. The concept of a threshold is crucial here. As people begin an imposed transition, they enter a liminal space, a 'betwixt and between' status which renders them more vulnerable. Turner (1969, p.95) explains that 'liminal personae' (threshold people) are being reduced or ground down before they can be "fashioned anew and endowed with additional powers to enable them to cope with their new station in life". We found no suggestion of additional powers during early parts of journeys. Rather, emotional stress responses dominated, leaving people cognitively vulnerable and incapable of action.

Research Question 2: How do service and system factors impact vulnerability during the journey?

Our analysis revealed a hitherto unidentified type of touchpoint that lies within wider service systems. We therefore extend existing touchpoint classifications to incorporate *'system-owned'* touchpoints. This finding is important because although journey literature has started recognizing that not every important touchpoint belongs to the focal organization, the empirical literature has not yet gone beyond Lemon and Verhoef's (2016) suggestion that 'partner-owned' touchpoints (those jointly designed or controlled by partners such as advertising agencies or distributors) should be differentiated from the 'brand-owned' touchpoints that are under the control of the focal firm.

Service and system factors that increase consumer vulnerability.

We identified five key organizational factors that increased consumer vulnerability. Three (power imbalances, system design, and institutional logics) lie within the wider service system, while two (brand resistance and the social servicescape) are controlled by focal organizations.

Power imbalances exacerbated feelings of vulnerability. This often happened during the first encounter that kickstarted the journey, resulting in feelings of helplessness:

"*Why did he use a Latin name? Why didn't he say that it's cancer? This is my cancer! But because he was a qualified doctor, he thought he was better than me, and called it by its Latin name. Asshole. The only person that looked stupid was him"* [David, Patient].

The power imbalance between provider and consumer is apparent here. While most encounters were less extreme than this, many recalled feeling small and powerless not solely because of the news they had just received, but also because of the nature of the interaction. Ironically, David's reference to 'my cancer' suggests that he was faster than many of our consumers in grasping the magnitude of their situation. Cognitive vulnerability had rendered many people unable to comprehend what they were told. Interactions with busy providers who were often less than patient with people as they struggled to digest information compounded these feelings of vulnerability. David's projection (he looked stupid, not me) can be interpreted as an attempt to regain some agency, some control, over the perceived threat to his identity. His identity is threatened multiple times: he has terminal cancer and is being made to feel stupid. Whether the doctor's superiority complex (he thought he was better than me) was real or perceived is irrelevant in this context. The feelings invoked, and David's resulting anger and resentment, are what matter.

System design impacted consumer vulnerability in multiple ways. References to an 'alien' situation emerged among narratives, as people faced an unfamiliar and complex system:

"It's not just the hospice. It's the whole corroboration. You need to know what is available, what it does, how you get access to it, and what the benefits are, because, without those things, you don't know, because you're walking into a strange world that you've never been involved in" [Pete, patient's husband].

Pete's quote gives insight into his vulnerability stemming from marketplace alienation, which is an individual's feelings of marketplace powerlessness, normlessness, and estrangement from a system that a person needs to engage with (Allison 1978). His reference to a 'whole corroboration' suggests how large and powerful he perceives the system. His vulnerability is apparent in his description of a 'strange world', which references his feelings of normlessness, which can arise when situations are poorly understood (TenHouten 2016). Nevertheless, there is a determination in Pete's quote. He wants to find out more, to understand this 'strange world', and how to gain access to regain some control. Pete's example is usual as it was companions, rather than our primary consumers, who first attempted to seek some empowerment.

Another constant theme was a lack of coordination between wider system parts. Jack's story is typical:

"You're told you've got Motor Neuron Disease, which has only got six months to three years survival rate. So, we're told by him [the doctor], and that's it, I walked out the door with nothing, no information. He said, 'The specialist nurse will contact you,' which was seven weeks later, and it took us six months from the time that Barbara was diagnosed to get to the stage where we had all the various people in place." [Jack, patient's husband].

Jack and Barbara's experience goes beyond an example of poor service. It is a case of consumer exclusion, which occurs when systems, however unintentionally, fail to serve adequately (Fisk et al. 2018). Their vulnerability, Barabara's stemming from biophysical reasons and Jack's from secondary vulnerability, is compounded by exclusion from desperately needed services. Consumer exclusion is the antithesis of consumer normalcy. Exclusion leads to marginalization and isolation, intensifying and perpetuating feelings of vulnerability (Hamilton et al. 2016). Jack's reference to their likely journey trajectory and the length of the delays to getting help illustrates how significant such delays are to feelings of helplessness for consumers.

Institutional logics are practices, values, assumptions, and beliefs that guide behavior. We identified journey delays resulting from disagreements between provider agents as to when to move from curative care to palliation:

"She [the doctor] looked at me and said, but that is a sortable condition! And I wanted to say yes, but his life isn't! I think at an acute hospital they want to cure what is in front of them, and they don't get the bigger picture" [Emma, nurse].

Unlike the doctor, who focused on the condition, Emma focused on the person. Institutional logics result from training, specializations, and internalized mental schemata. In our case, the dominant logic among doctors in the wider service system was to cure. As well as causing delays to consumer journeys, this removed choice, rendering consumers powerless. For some, this meant that a move to EOLC came too late, and the choice of where to die was denied. Doctors in the wider system often blamed scarce community resources, claiming the system lacked agility. Community doctors often blamed resource and coordination issues. Traveling companions whose relatives had died in hospitals instead of their preferred place at home lamented 'the system' without pinpointing what had gone wrong. Only nurses, who revealed a different set of logics, blamed doctors for hindering journey progress, because *"their whole ethos is around preserving life"* [Sam, hospice nurse]. Individual choice is central to definitions of consumer vulnerability (Hamilton et al. 2016). We identified entrenched institutional logics within the wider service system were responsible for removing choice for many.

Brand resistance emerged as the first firm-controlled problematic area, slowing journeys, and increasing consumer vulnerability. Our consumers, already vulnerable due to the innate fear arising from natural survival tendencies prevalent after diagnosis, now faced an additional fear: fear of a service designed to help them. Such resistance is typical to many negative services, which amplify consumer anxiety (Berry et al. 2015). Cognitive vulnerability hampers rational evaluation (Pillay 2014), often leading to misattribution, where consumers associate the negative service, rather than the trigger event, as the target for their anxiety (Singh and Duque 2012). A further possible reason for resistance is identity protection. Research into non-profit organizations suggests using such organizations compounds feelings of powerlessness (Tanner

and Su 2019). We did find some evidence to support this theory, as Terry and Jane's story highlights:

"And he was saying "But they're all volunteers! I can't go and ask them for help". And I said no, they're not volunteers, they're paid professionals" [Jane, bereaved daughter].

Terry thought engaging with volunteers would have made things worse for him, as though he did not qualify for charity, or would feel he was a burden or dependent. Such thinking is problematic because resisting help in this way compounds helplessness and aggravates vulnerability. Heightened cautiousness and risk perceptions surfaced.

We also found widespread resistance to the brand name 'hospice' frequently referred to as *'the death house'* or resembling '*an old person's home'*. Eve's poignant story illustrates a reluctance to engage with hospice services. Eve's eight-year-old daughter died in hospice, yet she recalls how initially steadfast she had been:

"We knew it was terminal. She had brain stem cancer, so there's not a lot to know because there haven't been many studies, and every child has been different with it. And every child has died differently. So, no one could tell me what to expect. I didn't know what to expect. I just knew back then that I was adamant she wasn't going into hospice" [Eve, bereaved mother].

It was not resistance to death itself that Eve refers to. Her acceptance of her daughter's imminent death is clear (she knew it was terminal). For Eve, and many like her, the brand name itself was problematic. Her imagination succumbed to the myths of a 'death house for old people' as a learned fear, resulting from conditioning (Gross and Canteras 2012), took hold. Few would argue that Eve's situation is extreme. Yet, she remained adamant. These results support a small amount of recent research that paradoxically finds a negative relationship between perceived adversity with one's situation and willingness to engage with services that can help. Theoretically, the reason is a fear of compounding feelings of vulnerability already experienced (Tanner and Su 2019).

The social servicescape. Hospice servicescapes were perceived as places that reduced stress and soothed people. Our reference here is the social servicescape, which incorporates other consumers: their presence, emotions, and behavior that impact the emotional and behavioral responses of others (Tombs and McColl-Kennedy 2003). Resource constraints meant choosing a private over a shared room was not always possible. Consequently, some witnessed other people dying:

> *"There was a room opposite that people kept being moved into to die. We watched three people, and three families go through that room and die in the first few days, and that was enough for me, and I said, OK, I don't like it. We need to get out. Let's go! And my dad was keen to leave then, too"* [Nicola, bereaved daughter].

Tombs and McColl-Kennedy (2003) contend that conformity to social norms within a given context impacts a consumer's affective state. In our case, consumers were normless, but what they witnessed certainly resulted in them feeling more fearful, defenseless, and vulnerable. Nicola's quote also illustrates the agency that began to emerge for some as their journeys progressed. Nicola and her father found the situation so traumatic that they took back control and left.

Service factors that reduce vulnerability

Two service factors emerged as ways to reduce vulnerability, both under the control of the focal organizations. Both are elements of the extended marketing mix: place and people.

Place, in terms of the physical hospice servicescape, came as a welcome surprise, delighting people and eliminating earlier typical misconceptions (old person's care home). Amazing facilities, tranquility, and serenity provided an oasis of calmness and safety. Ironically, this is the meaning of hospice: it is the root of 'hospitality' and was used centuries ago to signal a place of rest and protection (Marshall 2017). For most people, arrival at hospice prompted a complete opinion transformation from 'death house' to 'the right place'. Importantly, this serenity alleviated some fears, soothing vulnerability and introducing some perceptions of being safe. Keith explains this transformation was not possible with literature or websites:

"I'm less scared now, but I had to feel the atmosphere. There is something about the place, it's a lovely, lovely, friendly place, and until we'd been and seen it and felt it, I don't think anything really would have lessened our concerns and fears" [Keith, parent].

Research shows that cathartic spaces, which Higgins and Hamilton (2019) term therapeutic servicescapes, can transform emotions. The profundity of the transformation we uncovered cannot be underestimated. In fact, for some, the transformation from feeling insecure to secure was so profound that supernatural terms were used to described it:

"You can just feel the magic. The magic of being here" [Lucy, parent];

"it's a totally different world, I couldn't believe it" [Kim, patient].

People, too, in terms of frontline staff in our EOLC units, alleviated feelings of vulnerability for consumers. Like the servicescape, staff conveyed a sense of serenity and provided reassurance that no earlier communications accomplished. We again identified an element of the sacred. On multiple occasions, hospice nurses were given a status of hierophanies *"they are angels"* [Ronnie, patient's husband] and superheroes *"the Hospice at Home sort of turned up in their capes, really. That's how we felt"* [Wendy, bereaved wife]. Consumption can be a way of experiencing the sacred, when within a consumption experience, something of a different world manifests itself (Belk et al. 1989). Multiple references to frontline staff being *'angels'* and *'saints'* are clear indications of hierophany, while references to superheroes *'in capes'* is a further example of staff being awarded supernatural status. The contrast with hospice staff and early encounters with hospital doctors was remarkable:

"Out there I did what I was told, basically! I think that was one of the things I found most difficult, I had no control over what was happening. They were telling me. I mean, they were doing it all for my benefit, but you just feel really helpless, really, and I haven't felt that here, so that's been really good" [Peggy, patient].

Frontline staff helped to restore consumer agency in multiple ways. Many mentioned feelings of helplessness being alleviated, in similar contexts to Peggy. Others focused on emotional support, being given choices, and being involved in decision-making. Multiple references to identity were particularly poignant:

"Whether you're dying of cancer, or you've fractured your femur, you're traumatized, out of your comfort zone, vulnerable. But you are still someone's husband, wife, son, or daughter. Here, they have treated him like a human, like an individual" [Claire, patient's wife].

A well-established body of consumer research reflects how consumption impacts identity. A small amount of journey literature has examined identity from positive stances: surfing practices (Akaka and Schau 2019), tourism (Gyimóthy 2000), and student sojourners (Vredeveld and Coulter 2019). Our findings show that in the direst of circumstances, when identity threats are intense, frontline staff can make a profound difference by helping consumers to preserve their identities and lessen their feelings of vulnerability.

Research Question 3: How do traveling companions influence agency and feelings of vulnerability?

We have shown that traveling companions were almost as vulnerable as primary consumers, particularly at the beginning of their journeys. Their initial stress responses and cognitive vulnerability manifested often, their sense of disorientation and ambiguity during liminality apparent, the threats to their own identity due to role changes obvious. They too were impacted greatly by the service and system factors discussed previously. However, despite their vulnerability, we found traveling companions found agency for themselves and their fellow travelers. We structure this section into Hewson's (2010) agency classification comprising individual, proxy, and collective. In line with Hewson, we use the term agency to refer to intentional action to control, exert power, and make things happen, thus reducing vulnerability.

Individual agency entails a person acting on their own behalf. It is the most fundamental element of human agency (Hewson 2010), yet it was relatively uncommon in our results. We did find, however, that companions claimed individual agency by relinquishing care to professional EOLC services in response the situation reaching crisis point:

"You just get weary, yes and guilty…you promised that you will do this, but it was getting to be unsustainable. Eventually I said 'Look, I can't manage'" [Iris, bereaved wife].

Companions took great pains to explain how hard they had tried to maintain the status quo, but, like Iris, their situations had become untenable. Many described feelings of failure by acknowledging the need for referral to professional help, the sense of powerlessness and humbleness typical to feelings of vulnerability apparent. These findings also reveal the significance of the traveling companion not just as a friend or supporter but as someone who instigates and impacts journey progress, albeit reluctantly.

There was also some suggestion that some traveling companions found agency for themselves through information seeking. Feelings of empowerment resulted from information clarity, as Abbie, a mother of a child very close to end of life, explains:

> "*We're quite prepared now. I said to the doctor, 'tell me how it's going to happen, talk me through the process.' And she has, and I trust her"* [Abbie, patient's mother].

The feeling of being 'quite prepared' is in stark contrast to earlier feelings of vulnerability due to the knowledge disadvantage we found so prevalent at journey outset. The reference to 'trust' is also of significance here, demonstrating the crucial importance of clear information to reduce vulnerability. Agency requires action (Hewson 2010). Drawing on her own emotional resilience to request a detailed explanation of how her child will die enabled this mother to feel more in control and therefore reduce her own vulnerability.

Proxy agency is when a person acts on behalf of another. We identified multiple examples of companions acting on behalf of primary consumers by intervening with numerous gatekeepers. Companions followed up on scan and blood results, protested delays, and directed agents to others in the wider system. Overall, they took control of multiple aspects of the consumer's journey. Indeed, we found it was the traveling companion, not the primary consumer, who acted as the project manager (Bettencourt et al. 2022). Ruth's interventions are typical:

> *"After an x-ray a fortnight previous, and still no appointment, I phoned the hospital myself. I had to phone to get an appointment for John to be told they couldn't do anymore for him. Then after days, I had to phone the GP… they'd all left me sitting at home with a very ill man!"* [Ruth, patient's wife].

Sometimes, attempts to control the situation failed, at times with tragic consequences. Gillian had attempted to act on behalf of her sick husband on multiple occasions: she had telephoned the family doctor and the hospital consultant several times, and each time had been told, due to patient confidentiality, that his illness could not be discussed with her. She had then begged for a bowel cancer test for him, but the power remained with the providers who insisted on a diagnosis of irritable bowel syndrome. She recalls her reaction to the terminal diagnosis:

"I had been begging for help and then, as soon as you get the terminal diagnosis, GPs just knock at your door randomly and nurses are there. We were so angry, and I was going to kill this doctor. I was properly going to sheath him. I was so, so angry. So, we shut everyone out. I said, 'No hospice nurses, don't come knocking!' It was just like vultures circling ready for the kill. That's what it felt like." [Gillian, bereaved wife].

In comparison to Ruth, who managed to intervene successfully for the primary consumer, Gillian's multiple early attempts at proxy agency failed. Her vulnerability from subjugation by the more powerful doctors and systems remained. However, she acted again, by 'shutting everyone out, refusing help from hospice nurses and taking control of her husband's care for a short while. The outcomes of the actions of Ruth and Gillian are opposites in that Ruth speeded up access to EOLC services while Gillian slowed it down, but both show how traveling companions shape journeys while attempting to regain agency for primary consumers.

Collective agency occurs when people who share common goals take action to achieve them (Hewson 2010). We have highlighted numerous instances where companions have helped primary consumers along the journey, demonstrating a true social journey with common goals previously missing from the empirical journey literature (Epp and Price 2011; Hamilton et al. 2021; Thomas et al. 2020). As predicted by CAS theory (Ellis et al. 2017), we identified provider agents finding local solutions to problems, despite inherent complexity. These often relied on collaboration with traveling companions, especially where time was limited, and formal arrangements hindered progress:

"If we have really good supportive families, you can get people out, and it is about working together and really pulling out all the stops" [Becky, hospital nurse].

Collective agency requires planning and cooperation between parties to achieve common goals. Here we have evidence of a type of collective agency hitherto overlooked: a collective not consisting of a consumer network, which recent conceptual literature calls for (Hamilton and Price 2019) but comprising provider agents and traveling companions. Far from having any formalized procedures or intuitional arrangements, these collectives relied on

"a Sellotape and staples way of, 'oh you do a bit, and we'll do a bit"
[Heidi, hospital frailty consultant].

Nevertheless, by sharing common goals, they could act collaboratively to achieve them. Importantly, this empowered the primary consumer insofar as their actions enabled them to achieve their goal which for many was to die at home rather than in hospital.

Theoretical Implications

Most existing journey literature focuses on motivated, agentic consumers, who travel solo through a path-to-purchase with a single firm. In contrast, we examine a consumer journey that is kickstarted by a catastrophic situation that makes people (more) vulnerable. Ours is the first journey study to incorporate navigation of a negative service nested within a complex system and is the first empirical journey study to consider traveling companions. Our contribution is a novel insight into reciprocity: consumer vulnerability shapes the journey, while the nature of the journey shapes consumer vulnerability. Traveling companions, themselves rendered vulnerable by such journeys, significantly shape the journey and influence vulnerability.

How vulnerability shapes the consumer journey

When people are in a catastrophic situation, they face a journey that is significantly different from the three-stage (i.e., prepurchase, purchase, and postpurchase) path-to-purchase model underpinning much journey research. Most path-to-purchase journeys draw on previous experiences before need recognition leads to a search for solutions and choice considerations (Lemon and Verhoef 2016). The traditional model suggests consumers are rational decision-

makers who make optimal, informed choices. In contrast, we identify a journey that begins with emotional and cognitive vulnerability: natural negative reactions to a stressful and unfamiliar situation (Gross 2015). This vulnerability is additional to that caused by biophysical or environmental factors. Lacking normative guidance, and struggling to cope with emotional stress responses, we find cognitive vulnerability leads to an inability to grasp facts and information as quickly or effectively as people would ordinarily. The 'brain-fog' caused by this extreme vulnerability renders traditional marketing communications ineffective, and compounds vulnerability. Vulnerability initially greatly slows down journeys. Emotions prevail, and consumers feel disorientated and helpless. Our results, therefore, challenge the dominant journey model accepted in most journey research.

Our study answers calls for journey research to consider wider roles beyond those of customers (Hamilton and Price 2019). We demonstrate empirically that the initial state of inertia progresses to a realization that such journeys entail unwelcome and frightening new roles. Consumers resist relinquishing current roles and attempt to repel new ones because they perceive new role expectations beyond their recognized capabilities. Such role changes strike at the core self, posing threats to identity and rendering consumers more passive and powerless. These threats result in a phase of liminality, a space 'betwixt and between' (Turner 1969, p.95) their old and new identities, adding to self-perceptions of vulnerability and leading to further journey delays as people falter to come to terms with new identities. Only one previous journey study (Nakata et al. 2019) identified a liminal phase, suggesting that medication compliance vacillates between conforming and disregarding medical directions. Our results extend this small knowledge base and suggest that liminality may be even more significant to some journeys than previously thought, as people attempt to cope with threats to their identity.

These findings provide empirical insights into how consumers experience different types of vulnerability, often concurrently, within a single consumer journey. In our case, primary

consumers were already vulnerable from a biophysical perspective. Their traveling companions were secondary vulnerable. Both had to navigate their journeys because of catastrophe, and deal with their own and each other's negative emotional responses, cognitive vulnerability, and threats to identity. Experiencing these different types of vulnerability, frequently simultaneously, led to acute self-perceptions of disorientation, disadvantage, powerlessness, and anomie. Such feelings starkly contrast with the consumer-owned touchpoints outside the firm's control referred to in the journey literature (Lemon and Verhoef 2016). When consumers are so vulnerable, their journeys are marked by a distinct *lack* of control.

Of course, a terminal diagnosis results in heightened fear and stress, but our extreme case is not the only one that impacts consumers in this way. For example, medical consumers are often more emotional and dependent than in other market spaces (Berry and Bendapudi 2007). Similar emotions have been documented in studies of refugees and asylum seekers (Cheung and McColl-Kennedy 2019), and children in care who are approaching adulthood and facing multiple identity threats (Hibbert et al. 2016). Even less extreme situations can render a consumer vulnerable, for example in situations where consumers have no prior experience and little knowledge. Poor literacy skills, or inadequate digital literacy can further impact feelings of vulnerability as consumers must navigate complex services and systems. What is unique here is that we show the impact of these co-vulnerabilities on the consumer journey.

The impact of service and system factors on vulnerability during the journey

There is increasing recognition that only some organizational touchpoints are under the control of the focal organization (Anderl et al. 2016; Kranzbühler et al. 2019). Lemon and Verhoef (2016) refer to these as 'brand-owned' touchpoints, differentiating them from 'partner-owned' touchpoints (e.g., those managed partly by marketing agencies or distribution channel partners). We extend this classification to incorporate *system-owned touchpoints*, controlled by organizations outside the focal firm that significantly impact consumer journeys. We now focus

on those brand-owned and system-owned touchpoints that we found had a major impact on consumer vulnerability.

Brand-owned touchpoints did not all have the same influence on consumer vulnerability. Some increased and some decreased it. Hence, our findings suggest that consumer vulnerability ebbs and flows throughout the journey. While it has previously been argued that vulnerability emanates from specific contexts and differs from context to context (Baker et al. 2005), we demonstrate that consumer vulnerability is fluid *within* a single journey, and changes, sometimes quite significantly, in response to different touchpoints that are under the control of the focal organization. Some encounters with frontline staff in the focal units delighted consumers. Frontline staff were highly skilled in calming anxiety, offering choices, and making people feel safe. Yet, when people contemplated the hospice brand before experiencing it, feelings of vulnerability increased. While this finding undoubtedly has managerial implications for the brand name itself, it also supports a small but significant body of literature that suggests vulnerable consumers resist services designed to help them because they are protecting their identity (Tanner and Su 2019). Already vulnerable, using non-profit 'charity' services compounds feelings of dependency and powerlessness. Resistance may therefore have agentic underlying reasons. Such resistance is not limited to EOLC but has been identified in several services that exist to help vulnerable consumers, including, for example, financial services designed to help the poor, mental health services to treat depression, and weight loss services to reduce clinical obesity (Tanner and Su 2019).

The second brand-owned touchpoint that increased vulnerability was the social servicescape. In our case, it intensified fear and vulnerability when people witnessed others very close to death. Yet, the physical servicescape had the oppositive effect: it soothed, restored feelings of safety, and alleviated vulnerability. Originally referring only to the physical landscape, the servicescape concept was expanded to include the social environment (Bitner

2000). Today, knowledge exists regarding effective physical servicescape design, notably for therapeutic servicescapes (Higgins and Hamilton 2019). There is also a growing body of knowledge about problematic social servicescapes, usually about perceptions of unreasonable behavior by other customers and the strategies used by the firm to manage these. Only recently has research recognized the interplay between physical servicescape design features and the possible increase in negative social interactions (Furrer et al. 2023). Our study identifies an unintentional negative spillover: the design of the physical servicescape caused spillovers resulting in negative social servicescape experiences. Of particular importance is that these negative experiences led to heightened vulnerability among consumers, even though the physical environment had all the hallmarks of a therapeutic space. Here, we found vulnerability to be infectious, spreading between consumers. While such spillovers have yet to be fully explored in the literature, we suggest that these take on heightened importance for, for example, hospital departments like oncology, ERs, mental health units, and drug rehabilitation centers.

System-owned touchpoints emerged as highly important because they made consumers more vulnerable throughout their journey. Although these experiences were outside the control of the focal organizations, consumers did not separate brand-owned from system-owned touchpoints when narrating their journey experiences. To them, any touchpoint that impacted their journey is important. Yet, despite recognizing the need to consider complex systems (Kranzbühler et al. 2019), existing journey literature and existing touchpoint classifications (Anderl et al. 2016; Lemon and Verhoef 2016) fail to acknowledge critical touchpoints that reside in wider service systems. Hence, our extension to incorporate system-owned touchpoints is an important contribution to consumer journey knowledge.

We found the CAS lens to be highly beneficial in enabling our analysis to go beyond dyadic encounters, allowing a richer analysis of local practices and the ways these shape consumer journeys. CAS does not make services less complex. Rather, it provided a way of examining

the enormity of the system through which people must navigate, enhancing appreciation of the full journey and providing a better understanding of why consumers may find a service confusing and frightening. It also reveals why systems do not necessarily respond as quickly as people would like. It helps to discover pressure points and barriers where the service did not respond as an integrated system, and how this eventually impacts journeys. Regarding consumer vulnerability, our lens uncovers power imbalances in service encounters that kickstarted these journeys. Incorrect knowledge assumptions on the part of providers often leave consumers feeling powerless and inferior. Already feeling powerless, the complexity of navigating this system with no normative guidance, and poor integration of provider agents, further alienates already vulnerable consumers. We found including provider agents highly beneficial, uncovering insights into entrenched institutional logics that would have been overlooked without their input. This is important because our results show consumer choice, so central empowerment, to be adversely affected by these entrenched institutional logics, compounding vulnerability and delaying consumer journeys. For some, the resulting service was so poor that it excluded the people it exists to serve.

Some journeys travel through systems more diverse than ours. For example, the journey through homelessness incorporates government agencies, welfare systems, local charities, social shelters, and housing organizations. Children in foster care have co-vulnerabilities, often including secondary vulnerability due to their biological parent's drug or alcohol dependency, and their journeys incorporate health systems, child welfare agencies, schools, and family courts. CAS theory predicts poor communication, ineffective coordination, a lack of inter-collaboration, and problematic institutional logics as typical to many complex systems (Ellis et al. 2017). Thus, our findings are unsurprising in such complex systems. What is surprising is that extant journey literature has until now failed to consider the ways in which such systems impact vulnerability and consumer journeys.

Traveling companions influence agency and feelings of vulnerability

Journey research is only beginning to realize the centrality and reality of traveling companions, with the extant journey literature focusing almost exclusively on solo travelers. This is despite the certainty that most are collective experiences (Thomas et al. 2020). The vulnerability we identified among traveling companions cannot be underestimated. For some, their stress responses were on par with that of primary consumers, and we found widespread and severe cognitive vulnerability among them. However, the threat to their identities made them particularly vulnerable as they battled identity transitions imposed on them. Hence, we identified a new type of vulnerability that is not secondary vulnerability solely because they care for others, but because they navigate the journey with them.

We found traveling companions to be of utmost importance to the journey itself. Despite their own vulnerability, manifested by stress responses, cognitive vulnerability, and threats to their identities, traveling companions found agency throughout these journeys. We suggest that in journeys like ours, the traveling companion, not the primary consumer, acts as the project manager (Bettencourt et al. 2022). We identify ways companions found individual, proxy, and collaborative agency (Hewson 2010). They made things happen throughout the journey. It is noteworthy that among traveling companions, some examples of individual agency we detected were bittersweet: they held out, performing their role as caregivers usually for much longer than they should. Eventually, when they could cope no longer, they acted to access professional help, but with regret that they could no longer perform their unwelcome role. They then found proxy agency, acting on behalf of the primary consumer, often intervening and overcoming access barriers of gatekeepers and systemic complexity. Gaining access to EOLC, they reduced vulnerability for primary consumers and, with help from therapeutic servicescapes and frontline staff so skilled that they took on sacred statuses, restored agency.

In our case the roles of patient and caregiver are possibly more rigid than those in other social journeys where both parties may exert power and control equally. But, for journeys like ours where traveling companions are secondary vulnerable, agency likely comes from them. Examples may include the search for care homes for an elderly relative or gaining access to services for people with dementia or mental health problems. For other journeys, there may be power struggles between consumer and companion, such as drug, alcohol, or gambling addictions. Given that no prior empirical journey literature has focused on the roles of traveling companions in this way, this seems like an area ripe for further research.

A significant finding is the nature of the collaborative agency we identified. In some social journeys, a collaboration between consumer and companion is likely. In our case, collaborative agency came from traveling companions acting with professional agents to restore agency to primary consumers. Traveling companions therefore act as enablers, becoming active participants in service delivery and shaping the emergent system properties when professionals, stifled by ineffective institutional arrangements, cannot deliver the core service. These contributions enrich our understanding of consumer journeys. Such insights could have been overlooked without the CAS lens and the inclusion of companions and provider agents. We suggest that the roles of traveling companions are even more important than recent conceptual literature believes. We think agency among the secondary vulnerable that shapes consumer journeys may have been highly prevalent, but until now hidden from plain sight.

Managerial Implications

Our research has implications for managers within and outside EOLC. Problematic touchpoints under the control of EOLC providers include the brand name ‘hospice’, misconceptions about hospice units, and difficult social servicescapes. Despite its meaning as a place of rest and protection, hospice has become synonymous with fear and death. Rebranding is needed. However, brand name change is likely insufficient because death is taboo in Western society

(Hospice UK 2022), and words themselves do not change without cultural input. Our consumers were impressed by the professionalism of hospice staff and the therapeutic qualities of physical servicescapes. But how many people have experienced such places? Cognitive vulnerability, among primary consumers and their traveling companions, renders traditional marketing communications ineffective. Hospice needs a mainstream communications campaign to challenge current social myths, educate society on the reality of hospice care, and communicate 'the magic'. The solution to the final problematic brand-owned touchpoint is less resource-intensive. The design of the physical servicescape causes negative spillovers into the social servicescape. EOLC units do not need to be rebuilt. Bifold doors and concertina screens are an easy way to alleviate a difficult problem.

There are further problems for EOLC providers that are not solely under their control, but consumers do not differentiate between brand-owned and system-owned touchpoints. Problems residing in the wider service system include poor service encounters, ineffective collaboration, and entrenched institutional logics. These starkly contrast to the effectiveness of staff and processes within hospice units. Complex system instability lies with agent interactions, while imperfect knowledge is a major cause of provider frustration. There are opportunities for specialist hospice staff to train providers in the wider service system. Job shadowing could help as well. Such practices can shift thinking from an inward medical discipline focus to an outward emphasis on the consumer. The relatively new philosophy of patient-centeredness that treats people holistically is, we believe, a repacking of a consumer focus. Our consumers experienced a highly effective consumer focus among hospice staff.

Our findings have implications for organizations beyond EOLC and the system in which it is nested. We have examined a type of journey that is kickstarted when consumers find themselves in a catastrophic situation. Similar journeys include those demanded of refugees and asylum seekers, homeless people, those struggling with their mental health or addictions,

children in foster care, adolescents transitioning from child to adult social care, and those seeking care homes for relatives. Further examples include victims: of domestic violence, severe crime, terrorism, natural disasters, or major road accidents. Those facing contested divorces and a fight for access to children also have a difficult journey to travel. People facing such journeys are already vulnerable due to biophysical or psychosocial factors, spillovers causing secondary vulnerability, or environmental consequences. Our results provide useful insights into many services designed to help such consumers.

Managers of such services need to recognize that many organizational touchpoints have the potential to increase or reduce consumer vulnerability. Many journeys incorporate navigation of services and systems of which the consumer has little experience. Catastrophe can lead to natural stress responses such as helplessness, shock, dependency, fear, and sometimes sorrow. Consumers may find their coping strategies are deflated, and a type of brain-fog will impact their ability to seek, understand, and process information. Knowledge deficits will compound their vulnerability. The services designed to help them may be resisted because they are attempting to protect their fragile identities, as new roles for which they are unprepared are imposed on them. New ways to provide information and assurance are needed. The brand names of many services designed to help those in dire straits are shaped by social forces and become synonymous with taboo or victimhood. Examples of UK services that have changed their brand names include the Spastics Society (to Scope), a Women's Aid charity (to DASH – Domestic Abuse Stops Here), and the National Schizophrenia Fellowship (to Rethink). Whether or not managers decide a new brand name is necessary, all need to examine the ways their services are positioned in the mind of their potential target market. Repositioning as a service that can enable, provide choice, and restore agency may reduce fear and resistance toward them. Other brand-owned touchpoints include servicescapes, which must be examined for unintentional spillovers, ensuring they assuage vulnerability rather than exacerbate it.

Social servicescapes are often of utmost importance in such services to provide peer support. However, there will be instances within some journeys when a consumer's vulnerability is too public, and at these times, it is better to manage social interactions.

Journey mapping needs to move beyond brand-owned and partner-owned touchpoints to identify those system-owned touchpoints that have a major impact on consumers. Many consumer journeys entail navigating complex and diverse systems. Consumers do not differentiate between touchpoints owned by the brand and those that are not. Touchpoints in the wider service system that add to their vulnerability may have spillover implications for how they approach focal brands. Staff from the wider system need to be included in journey mapping exercises, fostering collaboration, and sharing insights into dominant logics and local practices. These practices can be overlooked when designing operational policies. When we included staff from the wider service system, we gleaned fresh insights into pressure points within the overall system.

Finally, journey mapping needs to incorporate traveling companions. Few consumer journeys are traveled alone, and our research demonstrates that it is the traveling companion who often project manages a journey. This is not to imply that traveling companions are not themselves vulnerable. Managers need to recognize that companions are secondary vulnerable, rather than assume that there is one vulnerable primary consumer and their companion who has agency. Indeed, it is time to realize that the target consumer may be a collective, and that vulnerability and agency will differ between members of the collective and at different times in the journey. The companion is so crucial to some journeys that managers who identify a solo traveler should appoint a critical friend to ride with them.

Conclusion

The journey concept is central to understanding holistic consumer experiences. Yet, most journey research considers consumers as agentic, rational-decision makers who make optimal, informed choices and undergo solo consumption journeys with single providers. In contrast, we examine accompanied journeys where consumers are vulnerable and must navigate negative services nested within complex systems. Our study is set within EOLC, though we suggest such journeys occur in other settings where consumers face catastrophic problems such as serious physical or mental health crises, homelessness, addiction, seeking asylum, severe road accidents, or contested divorces. Unlike journeys based on the common path-to-purchase model, we identify a new type of journey where consumer vulnerability shapes the journey, while the nature of the journey shapes consumer vulnerability. Emotional and cognitive vulnerability among consumers and traveling companions slows journeys. Identity threats lead to a resistance to relinquishing current roles and attempts to repel new roles which compound vulnerability and leads to liminality. We identify numerous touchpoints that impact vulnerability and extend current touchpoint classifications to incorporate system-owned touchpoints. We show how spillovers from some touchpoint can cause contagious vulnerability. We also present empirical evidence to support the concept of the social journey and show how traveling companions experience their own vulnerability, how this is compounded by their traveler role, and how they act as project managers to find agency for themselves and their fellow travelers. Thus, we show how consumer vulnerability ebbs and flows throughout the journey, as consumers experience different types of vulnerability, often concurrently, throughout their journeys.

EOLC is an extreme case. Unlike curative healthcare, mental health services, debt and addiction rehabilitation, or services offering sanctuary, EOLC cannot restore or enhance a consumer's previous state. Consumers requiring EOLC in cultures that require payment or suitable insurance are likely facing even greater challenges than the ones we identified, with

financial issues adding to feelings of vulnerability. We urge researchers and practitioners to consider vulnerability in consumer journeys and to take a more holistic approach to transcend those solo consumption experiences through single-provider firms upon which most journey research is based. We hope this wider perspective encourages marketers to answer more important real-world problems and ultimately make a positive difference in restoring agency to vulnerable consumers and their traveling companions.

The authors declare that they have no conflict of interest.

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Table 1. Selected empirical journey studies.

Empirical Study	Journey Concept	Method & Sample	Consumer	Vulnerable	Negative	Complex	Social	Focus/Aim	Theoretical Contribution	Managerial Contribution
Akaka & Schau (2019)	Identity projects over time	Surfing interviews (n=22)	✓	X	X	✓	X	How reflexivity contributes to value creation	Reflexivity within consumption journeys contributes to continued value creation	Opportunities for continued value beyond traditional touchpoints.
Anderl et al. (2016)	Online path to website	4 retailer clickstream data sets	X	X	X	X	X	Evaluation of the influences of online channels	An attribution mechanism for determining channel effectiveness and interplay	Helps advertisers develop integrated online marketing strategies
Barwitz & Maas (2018)	Path to purchase and post-purchase	40 interviews motor-insurance customers	X	X	X	✓	X	To investigate omnichannel choices along the customer journey	Understanding underlying consumer behavior throughout multi-/omnichannel journeys	Highlights the need for firms to better integrate channel touchpoints to enhance customer journeys
Crosier & Handford (2012)	Shopping trips	3 focus groups	X	✓	X	✓	X	To map the shopping journeys of blind and partially sighted people	Descriptive action research case study	To encourage service design to consider needs of blind people
De Keyser et al. (2015)	Search, purchase, after-sales	Telecom customer survey (n=314)	X	X	X	X	X	To extend a segmentation study within multichannel customer journeys	Identification of 6 customer segments based on a 3-stage customer journey	Provides retailers with insights into revenues and customer loyalty levels between segments for guiding strategies
Følstad & Kvale (2018)	Customer defined touchpoints	NPS Telecom customers (n=1700)	X	X	X	X	X	Applying transactional NPS for monitoring customer journeys	A customer journey mapping technique using Net Promotor Scores	A new way of leveraging already collected customer experience feedback
George & Wakefield (2018)	Initial purchase to membership	Big data from NHL team	X	X	X	X	X	To map subscription services customer journey	Understanding of customer journey from single ticket purchases to subscription	Insights for enhanced relationship building
Gyimóthy (2000)	Hedonic experiences	80 tourist narratives	✓	X	X	✓	✓	To understand how tourists evaluate hospitality services	Identification of roles embedded into 'traveler mythologies'	Starting point for segmentation of travelers

Halvorsrud et al. (2016)	Customer-provider interactions	Diary data (n=23) & broadband customer interviews	X	X	X	X	X	To introduce a new customer journey analysis framework	A customer journey methodology for evaluating customer experiences	Lens for examining service experiences and deviations from the intended service
Herhausen et al. (2019)	Customers' usage of self-selected touchpoints	Shopping journey survey (n=5092)	X	X	X	X	X	To segment customers based on their use of different touchpoints	Identification of five customer journey segments thus contributing to multichannel segmentation models	Practical model for building retailer journey strategies for different segments
Hu & Tracogna (2020)	Search to post-purchase	Motor insurance survey (n=338)	X	X	X	X	X	To determine multi-channel behavior across the customer journey for motor insurance	Determinants of multichannel journeys and webrooming when shopping for motor insurance	Insight into how to maximize conversion rates from search to purchase across channels
Kim et al. (2021)	3 latent stages: learn-feel-do	Digital data from online community (n=359)	X	X	X	X	X	To model consumer journeys for user-created programs posted in an online platform	A 3-stage framework for identifying journeys across diverse projects and publishers	Reveals efficiency of networking investment decisions when considering journey heterogeneity
Kranzbühler et al. (2019)	Firm–customer touchpoints	Energy provider's satisfaction data, and 3 experiments	X	X	X	✓	X	To examine the impact of outsourcing dissatisfying touchpoints	Insights into dissatisfying touchpoints and the impact of third-party outsourcing	Managerial guidance on conditions where touchpoint outsourcing can improve focal brand evaluations
Kuehnl et al. (2019)	Multiple touchpoints	2 surveys in US (n= 2300) and Europe (n=2312)	X	X	X	X	X	To develop a scale to empirically test effective journey design	Scale capturing consumer's conception of journey design and its impact on utilitarian brand attitudes.	Insights into the importance of customer journey design and ways to enhance their effectiveness
Li & Kannan (2014)	'Touches' through purchase decision	Big data from a hospitality franchise	X	X	X	✓	X	Evaluation of incremental value of individual marketing channels using customer touchpoint data	A conceptual framework that includes carryover and spillover effects across online channels	A tool to evaluate incremental channel contributions and revenues
McColl-Kennedy et al. (2019)	Customer experiences of multiple touchpoints	Text mining experiences of B2B heavy assets firm	X	X	X	X	X	To design and test a customer experience framework	A conceptual B2B customer journey framework	Key insights into B2B customer journey management

Mu & Zhang (2021)	Path to purchase & post-purchase	Big data for smartphone purchases	X	X	X	X	X	To examine the effects of marketing capability and brand reputation on customer journeys	Understanding of the impact of digital marketing activities and assets on the performance of firms	Spotlights marketing capability's impact in online environments
Nakata et al. (2019)	Medication compliance journey:	Patient interviews (n=29)	✓	✓	✓	✓	✓	To understand the nature of long-term usage experiences within a customer journey	A nuanced framework that highlights the customer compliance journey is liminal in nature and shaped by context.	Insights into ways healthcare providers can encourage medication compliance.
Rudkowski et al. (2020)	Customer experience touchpoints	Ethnography of 5 market pop-ups	X	X	X	✓	X	To understand the customer journey in marketplace-based pop-ups	Extends existing frameworks to marketplace-based pop-up customer journeys	Implications for touchpoint design across the pop-up retail experience
Srinivasan et al. (2015)	A know-feel-do pathway to purchase	Big data from US FMCG manufacturer	X	X	X	X	X	To investigate the impact of online activity with their interdependencies with the traditional marketing mix	A conceptual framework linking marketing actions to online consumer activity metrics along the customer journey	Managerial implications for media spending
Stein & Ramaseshan (2016)	Path to purchase and post-purchase	Retail experience narratives (n=28)	X	X	X	X	X	To investigate customer retail experience touchpoints from a customer perspective	Identification of 7 distinct experiential touchpoints in the customer retail journey	Guidance on orchestrating touchpoints for enhancing customer's retail experience
Sultan (2018)	A staged customer experience	Samples of telecom users in Kuwait	X	X	X	X	X	To identify touchpoints and their effects on relationships & word of mouth	Customer experience journeys comprise pre-touch, in-touch, post-touch, and service failure	Managerial insights into cost-effective touchpoint design in the telecoms industry
Trujillo Torres & DeBerry Spence (2019)	Cancer diagnosis to remission.	Multimethod mixed methods	✓	✓	✓	✓	✓	To examine how consumers valorize in traumatic experiences across long-term consumer journeys	Identification of 3 main valorization strategies in the consumer journey	Practical recommendations for enhancement of traumatic long-term consumer journeys
Vredeveld & Coulter (2019)	Sojourner experiences	Interviews overseas students in US (n=16)	✓	X	X	✓	X	To explore sojourner consumer journeys	Typology of 3 cultural experiential goals and their brand engagement	Insights into American branding and cultural symbols
Yachin (2018)	3 stages: Pre, active, reflective	Observation & discussion	X	X	X	X	X	To explore firm-customer encounters	A customer transformation model for micro-tourism journeys	Customers are cocreators of experiential tourism experiences

								along the micro-tourism journey.		

Table WebA1. Collaborating organizations and the services they offer

Alias	**Catchment Area (England)**	**Funding**	**Services**
Red Hospice	Affluent towns in North of England. Local population is older than average UK population. Significantly higher than average education and home ownership.	20% Govt. 80% charity	▪ 15-bed inpatient unit ▪ Day clinics offering fatigue, anxiety & Breathlessness (FAB) program ▪ Day care center offering Lymphoedema service, occupational & art therapy, physiotherapy, volunteer services. ▪ Counselling service ▪ Bereavement support service ▪ Chaplaincy ▪ Dementia caregiver well-being program
Yellow Hospice	Chain hospice in Northwestern City classified as economically deprived. Lower health status than national UK average, yet younger average age of local population.	40% Govt. 60% charity	▪ 26-bed inpatient unit ▪ Day center services including complementary therapies, crafts, yoga, relaxation techniques, education, and life stories ▪ Caregiver café for peer support ▪ Bereavement support service ▪ Chaplaincy ▪ Outpatient clinics: pain, lymphoedema, & breathlessness management
Blue Hospice	Highly prosperous Southeastern towns with high education attainment levels, high home ownership. Significantly older population than UK national average.	11% Govt. 89% charity	▪ 14-bed inpatient unit ▪ Day hospice ▪ Hospice@home ▪ Counselling and bereavement services ▪ Chaplaincy ▪ Specialist clinical care, physiotherapy, complementary therapies
Green Hospice	Northwestern County with mixed socioeconomic profile, serving areas in top and bottom of most/least deprived UK areas. Aging local population.	47% Govt. 53% charity	▪ 16-bed inpatient unit ▪ Hospice@Home ▪ Outpatient services including physiotherapy, complementary therapies ▪ Social worker support ▪ Counselling and bereavement services ▪ Chaplaincy

			▪ Caregiver's group
Purple Hospice	Eastern City but geographic scope encompasses some rural areas. Catchment area comprises significant pockets of social depravation. Local population is younger than UK average.	10% Govt. 90% charity	▪ 8-bed children's inpatient unit ▪ Family End-of-Life suites ▪ Respite services ▪ Adult & sibling support and wellbeing services ▪ Adult & sibling counselling and bereavement services
Inpatient Unit	General Hospital in economically deprived Northwestern City noted for its large wealth and health inequalities. Younger average age than UK population.	Govt. funded with research grants	▪ Specialist 12-bed inpatient unit for complex end-of-life needs staffed by specialist palliative care team ▪ Provides EOLC to patients in main hospital ▪ EOLC rapid discharge service ▪ Care for the dying volunteer service ▪ Complementary therapies ▪ Bereavement service
Outpatient Unit	Specialist Hospital with wide geographic catchment area comprising whole of the Northwest of England.	Team in Govt. funded hospital	▪ Multidisciplinary specialist EOLC outpatient Unit ▪ Specialist EOLC services for hospital inpatients ▪ Pain management services ▪ Occupational therapy ▪ Specialist social worker service
Specialist Lung Cancer Unit	Specialist unit serving 2 large metropolitan counties in relatively deprived areas of Northwest of England.	Team in Govt. funded hospital	▪ Specialist EOLC services for people with lung cancer ▪ Specialist clinical palliative care services ▪ Psychologist services ▪ Specialist social worker service
Hospice @Home	Market towns in affluent area of North England. Significantly higher than national average education, employment, and home ownership.	100% charity funded	▪ Provider of EOLC in the community, usually for people in last 6 weeks of life, for those people who wish to die at home

Table WebA2. Pathography participants (n= 257)

	Primary customers	**Traveling companions**			**Age**				**Gender**		**Socioeconomic Status**		
Alias	**Patients**	**Current Caregivers**	**Bereaved Caregivers**	**Total**	**13-34**	**35-54**	**55-74**	**75+**	**M**	**F**	**AB**	**C**	**DE**
Red Hospice	18	12	8	**38**		8	19	11	10	28	17	17	4
Yellow Hospice	16	7	5	**28**	1	6	9	12	12	16	12	12	4
Blue Hospice	18	4	9	**31**		2	17	12	15	16	14	14	3
Green Hospice	10	6	5	**21**	1	7	10	3	5	16	9	9	3
Purple Hospice	2	13	7	**22**	9	11	2		4	18	9	4	9
Inpatient Unit	9	16	4	**29**	2	8	13	6	13	16	17	10	2
Outpatient Unit	4	11	5	**20**	2	5	13		6	14	6	4	10
Lung Cancer Unit	9	9	N/A	**18**	2	2	10	4	8	10	4	8	6
Hospice@Home	2	4	44	**50**	2	6	28	14	9	41	30	14	6
Totals	**88**	**82**	**87**	**257**	**19**	**55**	**121**	**62**	**82**	**175**	**118**	**92**	**47**

Table WebA3. Senior staff interviews with collaborating agents (n=44).

Alias	**n**	**Senior Staff**
Red Hospice	6	Chief Executive; Director of Quality & Innovation; Clinical Director; Medical Director; Finance Director; Head of Nursing
Yellow Hospice	5	Chief Executive; Chief Nurse & Director of Quality; Chief Fundraising, Marketing & Communications Officer; Chief Financial Officer; Head of Nursing (Inpatients)
Blue Hospice	4	Chief Executive; Director of Patient Services; Medical Director; Chair of the Board of Trustees
Green Hospice	5	Chief Executive; Medical Director; Director of Clinical Services; Income Generation & Marketing Director; Operations Director
Purple Hospice	5	Chief Executive; Director of People & Resources; Director of Care; Clinical Educator; Head of Family Support
Inpatient Unit	4	Palliative and EOLC Clinical Lead; Associate Director& Clinical Governance Lead; Consultant in Palliative Medicine; Head of Nursing
Outpatient Unit	6	Specialist Palliative Care Consultant; Specialist Palliative Care Clinical Nurse Specialists (x2); Occupational Therapists (x2); Specialist Social Worker
Specialist Lung Cancer Unit	5	Specialist Palliative Care Consultant; Lung clinical nurse specialists (x2); Social worker; Occupational Therapist
Hospice@Home Provider	4	Chief Executive; Clinical Nurse Director; Head of Nursing; Quality Manager

Table WebA4. Interviews with staff outside collaborating organizations (n=22)

Alias	**n**	**Role in EOLC Provision**
Hospital Nurses	7	Working in geriatrics, respiratory, and cardiac units, all had administered EOLC in previous 6 months. Also responsible for aiding discharge for patients who want to die in their own homes.
Family Doctors (GPs)	6	GPs with responsibility for administering EOLC in the primary care system and referring to community EOLC.
Community Nurses	4	Community nurses administer EOLC to patients at home, working alongside other agents in the wider EOLC service system.
Care Home Managers	4	Responsible for helping residents and their families with Advance Care Planning and coordinating EOLC for their residents who wish to die at home.
Hospital Frailty Consultant	1	Provides urgent care and assessment for extremely frail patients and refers to EOLC where deemed necessary.

Table WebA5. Research questions mapped against utilized data

Research Question	**Customer Pathographies**		**Interviews with EOLC providers**	
	Primary consumers n=88	Secondary consumers n=169	Senior staff within collaborating organizations n=44	Frontline staff from wider service system n=22
How does vulnerability shape a consumer journey?	✓	✓		
How do service and system factors impact vulnerability during the journey?	✓	✓	✓	✓
How do traveling companions influence agency and feelings of vulnerability?	✓	✓		✓