

**WAYS OF COPING: UNDERSTANDING WORKPLACE STRESS AND
COPING MECHANISMS FOR HOSPICE NURSES**

by

LaToya JM Harris

BA, Vanderbilt University, 2002

MPH, Mercer School of Medicine, 2004

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Graduate School of Public Health

This dissertation was presented

by

LaToya JM Harris

It was defended on

November 8, 2012

and approved by

Mark S. Friedman, PhD, MSW

Assistant Professor

Department of Behavioral and Community Health Sciences
Graduate School of Public Health, University of Pittsburgh

Mary Beth Happ, PhD, RN

Adjunct Professor

Department of Acute and Tertiary Care
School of Nursing, University of Pittsburgh

Martha Ann Terry, PhD, MA

Assistant Professor

Department of Behavioral and Community Health Sciences
Graduate School of Public Health, University of Pittsburgh

Dissertation Advisor: Steven M. Albert, PhD, MSPH

Professor and Chair

Department of Behavioral and Community Health Sciences
Graduate School of Public Health, University of Pittsburgh

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Steven Albert, PhD

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LaToya JM, Harris, DrPH

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OBJECTIVE. Hospice programs consider nursing their primary source of professional services. Recruitment and retainment of hospice nurses has been a challenge in the last decade due in part to workplace stress. This research seeks to expand the current body of knowledge surrounding the coping process for this group. Additionally, this research explores the availability and adequacy of workplace resources in order to recommend how organizations can assist in the coping process.

METHODS. This study included registered and licensed practical nurses. Eligible subjects were invited to participate in focus group sessions. Participants also completed a survey that collected demographic information and assessed coping strategies through the use of the Ways of Coping Questionnaire. Interviews were audio-recorded and transcribed. Content analysis was performed on interview data. Descriptive statistics and bivariate correlations were performed on the quantitative data.

RESULTS: Hospice nurses reported that social support, humor and prayer/meditation were the most effective coping mechanisms. The majority of the participants shared that their hospice agencies offered no formal resources to assist them in times of stress. Informal resources emphasized individual efforts at ameliorating stress that offer little to no long-term therapeutic value. Quantitative results supported focus group feedback in regards to most frequently used strategies. Moderate associations were found between hospice nurse experience and playful problem solving and seeking social support.

CONCLUSION: Traditional approaches to combat workplace stress have focused solely on individual efforts. Organizations have an opportunity to develop quality workplace resources that consider the person-environment relationship and build upon coping strategies that nurses find most effective. This information challenges organizations to explore and make available beneficial coping resources with their staff.

PUBLIC HEALTH SIGNIFICANCE: Hospice nurses have been identified as a high-risk group for burnout and fatigue as a consequence of workplace stress. The results of this study indicate that there are disparate programs across hospice settings to assist nurses in coping with job stress. Further, hospice nurses consider these efforts to be primarily inadequate and ineffective. Future research should focus on identifying standard policies and practices that best protect this group from injury and illness and ensures the longevity of hospice care.

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perseverance [*pur-suh-veer-unhs*]: noun. steady persistence in anything undertaken; continued pursuit or prosecution of any business or enterprise begun; applied alike to good or evil especially in spite of difficulties, obstacles or discouragement.

“And let us not grow weary, for in due season we will reap if we do not give up.”

Galatians 6:9

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And above all these THANK YOU GOD!!! It is only through You that I AM!

1.0 INTRODUCTION

1.1 BACKGROUND

1.1.1 Understanding Hospice

How do we care for the dying? How do we ensure that those at the end of life maintain quality of life until their last breath? For over 40 years, hospice care has been the answer. Hospice care is a service provided to terminally ill patients who are approaching the final stage of life. The focus of hospice is the belief that every individual has the right to a pain-free and dignified death (National Hospice and Palliative Care Organization, 2008). The emphasis is on maintaining quality of life rather than life-prolonging or curative treatment.

Hospice is a care model designed to provide emotional, social and spiritual support to both the patient and the family (Hospice Foundation of America, 2008). The hospice philosophy recognizes death as the final stage of life and seeks to remove the stigma and fear that are associated with it. Through pain control, symptom management and psychological and

spiritual support, the hospice team cares for the “whole” patient (Krisman–Scott, 2003). Care is provided 24 hours a day, seven days a week and is tailored to each person’s individual needs and wishes. As such, hospice care is often considered the model for quality, compassionate and humane care (Dubois, 1980; Sheehan & Forman, 1996).

Hospice care does not describe a place. In fact, it can be provided in a variety of settings such as the home, a hospital, in-patient hospice facility, nursing home, or assisted living facility. Often used interchangeably with palliative care, hospice is unique in that patients typically have less than six month’s life expectancy (Hospice Foundation of America, 2008). Additionally, it is important to note that hospice is not limited to the care of the elderly or cancer patients. There are a myriad of life-limiting illnesses that qualify an individual as eligible for hospice care. Children and adults of all ages can seek hospice services.

1.1.2 A Historical Perspective

In the early eighteenth century the term “hospice” referred to a place of rest and comfort for weary travelers (Hoffman, 2005). The new concept of hospice as compassionate care for the dying began with the founding of St. Christopher’s Hospice in London, England, in 1967 under the guidance of Dr. Cicely Saunders. It was there that a focus on changing the way care was

provided to the dying emerged. As a result, there no longer was the need to prolong life through sometimes painful treatment. Instead, the comfort model that viewed the patient and family as a unit and emphasized the humanistic and holistic approach to patient care was solidified (Paradis & Cummings, 1986). Saunders believed that pain existed beyond the physical; therefore, care should address all the needs of the patient and family. An interdisciplinary care team would be responsible for providing these services.

The hospice movement in the United States (U.S.) gained momentum in the 1970s following a meeting between Dean Florence Wald of the Yale School of Nursing and Dr. Saunders in an attempt to recreate the hospice success experienced in England. Also paving the way for the transition to hospice care was growing acclaim for the publication *On Death and Dying* by Dr. Elizabeth Kubler-Ross (1969), which introduced new approaches and philosophies on the treatment of individuals with terminal illness and institutionalized care. Slowly these experiences created a climate in which the attitudes and perspectives toward death began to change.

America's first hospice was founded in 1974 with the opening of the New Haven Hospice in Connecticut. This initial model of hospice focused on providing care in the patient's home rather than the hospital setting. It opened as a free-standing, non-profit institution providing services through funding from the National Cancer Institute (NCI). Further

strengthening the movement was the creation of the National Hospice Organization (NHO) in 1978. Known today as the National Hospice and Palliative Care Organization (NHPCO), the group was responsible for the establishment of the first U.S. Standards for Hospice Care. These standards attempted to define minimum requirements for hospice care and provided a means to evaluate program effectiveness.

1.1.3 Today's Hospice

Many of the characteristics and practices of the New Haven Hospice are evident in today's hospice program. The original goal of hospice, to provide care and comfort to terminally ill patients through a holistic and patient-centered approach, remains a central tenet. The patient is treated for not only physical pain but also any psychological, social or spiritual distress that may prevent a peaceful death (Hoffman, 2005). Education and emotional support are provided to the patient's family and/or caregivers to assist in the transition from life to death.

The goals of hospice are achieved through a team of practitioners that includes nurses, physicians, chaplains, social workers and counselors. Today's hospice also continues to rely heavily on a volunteer workforce. In fact, there is a mandate to maintain a specific ratio of volunteer staff to paid employees for hospice programs to be eligible for Medicare

reimbursement (Colburn & Hiveley, 1993). Together the team collaborates with the patient and his/her family to develop an appropriate plan of care. (See Figure 1).

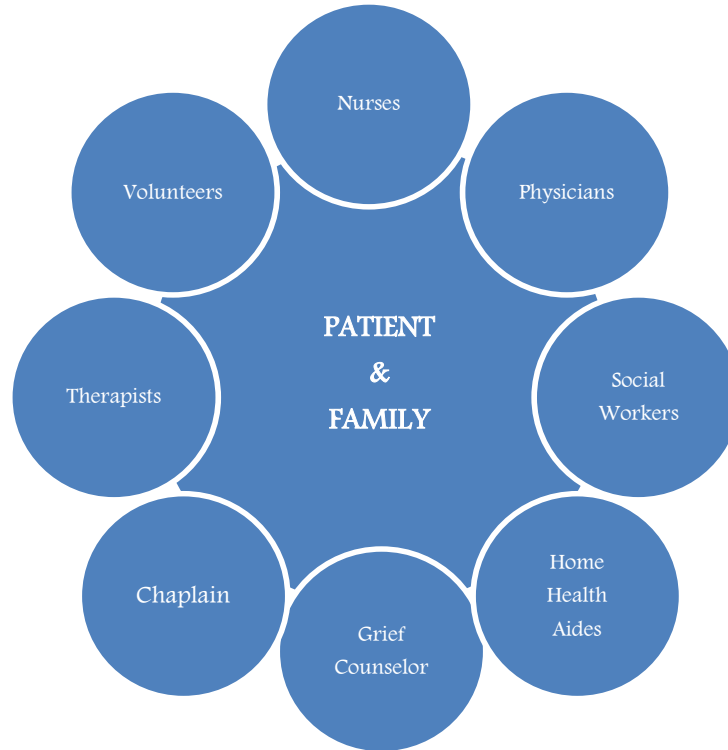


Figure 1. NHPCO Hospice Team Model
Retrieved from www.nhpc.org

From 1985 to 2005, the number of hospice programs in the United States increased from roughly 1,500 to more than 3,500, representing various care settings (Connor, 2007). A considerable portion of this increase is attributable to the establishment of the Medicare Hospice Benefit in 1983, which provides reimbursement for palliative and support services for enrollees. Additionally, an increase in the awareness of hospice services and the continued growth of the aging population, as life expectancy increases, have contributed to the

proliferation of hospice programs over the last decade. A more than 50% increase in hospice care was also seen between 2000 and 2009, with much of that growth in for-profit programs. Today there are a reported 5,000 hospice care programs nationwide (NHPCO, 2012).

Approximately 1.6 million patients received services from a hospice care program in 2010 alone. While unique users are an important measure, it is critical to consider the duration of care for hospice patients as well. According to a recent report, the average length of stay for hospice patients in 2010 was 67.4 days, up from 56.8 in 2006 (NHPCO, 2012). It is important to note, that length of stay can vary based on disease course, timing of referral and access to care. The provision of hospice care can occur in a variety of settings but mainly focuses on wherever the patient considers home. In 2010, the majority of hospices (58%) were free standing/independent, 21% were a part of a hospital system, 19.2% were considered a home health agency and 1.4% were a part of a nursing or long term care facility. Of these programs, a little more than a third (36%) were considered non-profit (NHPCO, 2009).

Hospice services are available to patients of any age, religion, or race. On average, patients are over 65 years of age with one out of three patients being at least 85 years old. Historically, most patients admitted to hospice had a cancer diagnosis. However, this has changed to include other life-limiting illnesses. Non-cancer diagnosis accounted for 64.5% of hospice patients in 2010 (NHPCO, 2012). The percentage of hospice patients covered by the

Medicare Hospice Benefit versus other payment sources was 83.8% in 2010 (NHPCO, 2012). Today, in addition to Medicare and Medicaid, private insurance carriers and other managed care programs also provide hospice coverage. Hospice care has quickly become an over \$10 billion dollar industry (Medicare Payment Advisory Committee, 2008).

1.2 STATEMENT OF PROBLEM

The need to attract and retain hospice nurses is critical to the future of hospice care. While the goals of hospice are achieved through an interdisciplinary team of dedicated practitioners, the hospice nurse is integral to the team. In fact, roughly 90% of hospice programs indicate that nursing is their primary source of professional services (Buckingham and Lupu, 1982). In response to the tremendous growth of the aging population and increased awareness of hospice services, hospice programs have proliferated over the last decade. As such, the demand for hospice nurses has grown exponentially. Hospice care has not been able to match this growth due to the existing nurse shortage that has plagued numerous specialties.

Workplace stress has been implicated from among the myriad of factors contributing to the nursing shortage. In particular, it has been said that maintaining the unique philosophy and expectations (providing total care to both patient and family) of hospice care has

contributed to the challenge of recruitment and retention within hospice care (Abendroth and Flannery, 2006). Because workplace stress also has the potential to negatively impact nurse well-being and patient outcomes, it follows that this issue can severely threaten the viability of the hospice nurse specialty and ultimately hinder the growth and success of hospice programs.

1.3 PURPOSE OF THE STUDY

This research seeks to expand the current body of knowledge surrounding the coping process for hospice nurses. It is an exploration of the coping strategies hospice nurses use and consider most effective against workplace stress. A special emphasis is on the use of social support and employee assistance programs (EAPs). In particular, the research focuses on the availability and adequacy of organization-based coping resources for this group of nurses. Identifying how organizations can assist in the process of coping through the development of interventions and policies is important to nursing practice. Organizations have the ability to not only reduce environmental stressors but also to enhance the coping strategies for hospice nurses through improved resources (McShane and vonGilnow, 2005). A comprehensive and proactive approach can positively impact nurse well-being. A healthy workforce translates into quality delivery-of-care for those patients requiring end-of-life care, which ultimately equates to

positive health outcomes (Munn–Giddings, et al., 2005). Lastly, organizations reap the benefits of improved job satisfaction, retention and recruitment.

1.4 SIGNIFICANCE OF THE STUDY

Occupational stress is a major health issue for many organizations today. In a recent study of American workers, two in five (41%) respondents reported feeling stress on the job; nearly half said they needed help in managing stress (American Psychological Association, 2012). Job stress can be defined as the negative physical and emotional responses that occur when job requirements do not match the capabilities, resources, or needs of the worker. Thus any factor in the work environment that an individual finds threatening that also exceeds the individual's ability to address it results in stress or strain (Antonovsky, 1979; Kyriacou, 1989).

Studies have shown that workplace stress is strongly associated with low productivity, high absenteeism and poor job performance (McShane and Von Glinow, 2005). Employees with high levels of stress have significantly higher rates of productivity loss than their counterparts. Likewise, medical costs for the organization and the individual, attributed to stress, are higher in this population. Employees exposed to prolonged stress typically suffer from psychological and physiological symptoms. According to the National Institute of

Occupational Safety and Health (NIOSH) (1999), chronic stress has been associated with negative health outcomes, including musculoskeletal disorders, psychological distress such as depression, injuries, and cardiovascular disease. Lastly, job satisfaction has been found to be inversely related to job stress, which is then linked with high rates of job turnover (Lazarus, 1999).

Workplace stress and burnout are recognized phenomena prominent in the healthcare arena. Left untreated, stress and burnout can negatively impact the delivery of care by healthcare workers (Munn-Giddings et al., 2005). According to Burke (2000), nurses encountering ongoing stress experience negative health conditions resulting in poor personal well-being as well as impaired job performance. These consequences can then impact quality and efficacy of patient care. Conversely, physically and emotionally healthy hospice nurses are better able to deliver quality patient care, which has been linked to improved patient outcomes.

Failing to recognize and address workplace stress for hospice nurses is a serious threat to the future availability of hospice care and the provision of end-of-life care (Hart, 2001; Shirey, 2004). New nursing trainees are reluctant to choose hospice care as a specialty because of its demands and strenuous working conditions. Nurses already working within the specialty often resign as a result of the overwhelming stress and ultimate burnout. In general, studies

have shown that more than half of all nurses leave patient care all together to seek jobs that are less stressful and less physically demanding (Hart, 2001; Kovner and Brewer, 2007).

Adding to this complex issue is the projection that the nursing workforce will fall 29% below demand by the year 2020 (Hospice and Palliative Nursing Association [HPNA] Position Statement, 2003). Additionally, the average age of registered nurses has climbed to 46.8 years with over 40% aged 50 years or older (BHPR-HRSA, 2006). This reflects an overall decrease in the number of younger nurses entering the workforce and an increasing number of nurses eligible for retirement. While specific data on the magnitude of the nursing shortage for hospice care are limited, there is no evidence to suggest that hospice will be exempt from the current trends. The American Hospital Association reported a nationwide RN vacancy rate of 8.1% in U.S. hospitals and a 7.9% vacancy rate specifically in long term care (American Healthcare Association, 2010). These startling statistics combined with the knowledge that as life expectancy increases so will the need for hospice care, truly underscore the importance of understanding the impact of workplace stress on hospice nursing and exploring how organizations can assist in the coping process.

1.5 RESEARCH AIMS

The primary aims of this research study are to:

- (1) Describe the primary ways of coping for hospice nurses.
 - (a) Explore the use of social support among hospice nurses as a coping mechanism;
 - (b) Explore the availability and adequacy of workplace programs intended to mitigate stress;
- (2) Understand hospice nurse perspectives on the most effective coping strategies; and
- (3) Recommend potential organizational resources that can aid in hospice nurse coping.

2.0 LITERATURE REVIEW

2.1 NURSING

Nursing has and continues to be a prominent force in the hospice movement. Roughly 90% of hospices indicated that nursing is a primary source of professional services in their programs (Buckingham & Lupu, 1982). An estimated 30,000 registered nurses work in a hospice/palliative care setting in the U.S. (Health Resources & Services Administration, 2004). According to the National Board for Certification of Hospice and Palliative Nurses (2009), 11,757 certified registered nurses are in hospice care. National demographics specifically describing the hospice nursing workforce are limited. However, demographics captured through membership surveys of the HPNA suggest that hospice nurses are predominately middle-aged, white females with less than a third holding an advanced degree (HPNA, 2007).

Although care is provided through a multidisciplinary team, nurses are responsible for pain management and monitoring vital signs and symptoms as well as rehabilitation. The traditional role of nursing in hospice care is expanded with added responsibilities for the

family or caregivers. In addition to caring for the patient, hospice nurses must also have the ability to teach basic nursing skills to the family and provide emotional and spiritual support.

Attributes of a hospice nurse include:

- Capacity to manage physical, psychological, social and spiritual problems of the patient and family;
- Ability to communicate, counsel and instruct in a compassionate manner;
- Ability to coordinate the many components of hospice services; and
- Ability to balance one's self-care needs with the complexities of continuous exposure to death (Connor, 1998; Dorbatz, 1990; Forman et al., 2003).

Nursing is therefore a pivotal component of the hospice model of care. Because of this, the availability and the well-being of hospice nurses are centrally important to the survival of hospice.

2.2 HOSPICE NURSES AND STRESS

There is evidence that suggests that healthcare workers experience high levels of psychological stress and stress disorders. According to the NIOSH (1999) and the Occupational Safety and Health Administration (OSHA) (2000), hospital work in general often requires coping with

some of the most stressful situations found in any workplace. While NIOSH and OSHA did not conduct research specifically examining hospice care, results are presumed generalizable to this specialty considering the unique and added demands of hospice care.

Even when psychiatric vulnerability and outside-of-work social stress were accounted for, work-related stress was demonstrated to be a contributor to anxiety and depressive disorders in healthcare professionals and hospital staff (Weinberger, 2000). Because of the continuous exposure to illness, healthcare workers are considered a high-risk group for job stress (Van Laar et al., 2007).

Based on this information it is of no surprise that nursing is considered a high stress occupation. Numerous studies have explored the nursing workforce and job stress. According to Lambert and Lambert (2001), a review of employee stress in healthcare settings across 17 countries found that nurses in the majority of countries experienced high levels of stress and strain. Dewe referencing Moreton-Cooper wrote that:

If you wanted to create the optimum environment for the manufacture of stress, many of the factors you would include would be clearly recognized by nursing staff as events which they encounter in their daily routine. These include an enclosed atmosphere, time pressures, excessive noise or undue quiet, sudden swings from intense to mundane tasks, no second chances, unpleasant sights and sounds, and standing for long hours (1987, p.15).

Dewe surmised that the daily work requirements inherent to nursing were in and of themselves stressful. The very nature and emotional demands of the profession make nurses susceptible to increased stress.

A review of the research in the area of nurse stress in the hospice and palliative care setting reveals that because of continuous work with the terminally ill, hospice nurses are considered a high-risk group for burnout, which is the ultimate manifestation of prolonged stress (Abendroth, 2006; Keidel, 2002; Payne, 2001). An additional research study showed hospice/palliative care staff had stress scores almost twice as high as those of newly widowed women and higher than women newly diagnosed with breast cancer (Vachon, 1987a). These nurses reported more sleep problems, decreased energy, and nervousness. Hospice nurses, unlike other health care workers, address not only the medical needs of the patient, but also provide education and emotional support to the family. Their relationship can often transcend the traditional or formal nurse-patient roles because hospice nurses frequently become emotionally connected to both the patient and family as they experience the process of death/dying along with them (Georges et al., 2002; McWilliam et al., 1993; Vachon 2001).

There is considerable disagreement in the literature with regard to whether hospice nurses actually experience higher stress levels than other nursing specialties. According to

some, levels of psychological distress for hospice nurses when compared to other types of nursing are actually lower overall. In a comparative study of hospice nurses and critical care nurses, results indicated that critical care nurses reported significantly higher work place stress than those in hospice (Mallet et al., 1991). This difference was attributed in part to the high level of commitment to the overall mission of hospice and the high sense of meaning and purpose to their work. Fillion and Saint Laurent (2003) found that end-of-life care was a source of satisfaction for hospice nurses and resulted in lower stress levels. In contrast, Munley (1985) and Gray-Toft and Anderson (1986–1987) concluded that hospice nursing is particularly stressful because it involves having to constantly cope with loss and grief. Others have found stress levels for hospice nurses to be on par with other nursing specialties, with the difference being seen only in the source or type of stress (Tyler and Ellison, 1994). Despite these varied results, it is clear that work place stress is a significant issue for nurses in hospice care.

2.3 MAJOR STRESSORS

Given the potential negative impact of occupational stress on the well-being of nurses, it is imperative to fully understand the sources of workplace stress and their implications for

hospice care. Extensive research on occupational stress has firmly established the relationship between work stressors, employees and organizations (Antonovsky, 1979; Burke, 2000; NIOSH, 1999; OSHA, 2000). When stressors exceed capabilities and resources, employees as well as the organization are negatively impacted. For employees, the results are typically low self-esteem, illness or injury, and poor job satisfaction. Employers feel the impact through increased absenteeism, diminished care and satisfaction and high turnover (McShane and Von Glinow, 2005). By identifying the major sources of stress, organizations can then provide resources to develop or strengthen coping skills or institute changes in the work environment that will reduce stress. Together these efforts will improve well-being for nurses, increase productivity and quality of care and ultimately improve the bottom line for the organization.

In general, workplace stress research has revealed that employee cognition, organizational constraints, interpersonal conflicts and working conditions are the four prominent categories of stress (Gary-Toft and Anderson, 1981; Kulbe, 2001; Payne, 2001). Employee cognition speaks to the individual's knowledge, skills and attitude. Has the employee been adequately prepared for the job? Organizational constraints often refer to the structure and culture of the work place. Are there promotion opportunities? Do employees participate in decision-making? Interpersonal conflicts refer to the relationships between coworkers, supervisors and subordinates. Are co-workers trusting and supportive of each other? Does the

supervisor encourage an open-door policy? Do nurses feel they have autonomy? Working conditions include safety at work, work hours and workload. Are shift work and long hours negatively impacting employees? Is staffing appropriately aligned with workload? The NIOSH expands upon these examples, adding the dimensions of work roles as another important contributor to work stress (1999). According to this explanation role ambiguity, conflicting expectations and multiple responsibilities can intensify stress.

Workplace stress as it relates to the healthcare setting and more specifically hospice care is shown in Table 1 (Baranowski, 2006). The results support the generalizations above but

Table 1 Hospice Specific Stressors

| Interpersonal | Health Care System |
|--|--|
| <ul style="list-style-type: none"> ▪ Conflicts with colleagues ▪ Poor communication among staff ▪ Low team morale ▪ Disagreement about goals of care ▪ Coping with patients' family dynamics ▪ Coping with patient psychological issues ▪ Poor relationship with patient/family ▪ Patient/family stressors (degree to which patient/family accept illness and impending death, rate of patient's deterioration) ▪ Difficulty controlling patient's pain/symptoms ▪ Difficulty predicting when death will occur ▪ Coping with death and dying ▪ Long term relationships | <p style="text-align: center;">Professional</p> <ul style="list-style-type: none"> ▪ Lack of experience and preparation ▪ Moral and ethical dilemmas ▪ Confidence in skills ▪ Adverse effects of treatments /Treatment errors ▪ Professional liability |

have been condensed to describe workplace stress in three main areas; interpersonal, the healthcare system and professional level. Gary-Toft and Anderson (1986-87) found that

consistently coping with death was a prominent source of stress for hospice nurses. Vachon (1987a) argued that the major sources of stress in the hospice setting originated outside the work environment and in ambiguous professional roles, rather than from the actual work of caring for dying patients and their families. In a comparative study of hospice nurses to those in other nursing disciplines, emotional demands and uncertainty ranked as the 2nd most stressful aspect for hospice nurses. These findings were further supported by several studies that identified major sources of stress stemming from leadership style and support, workload, relationships with other staff, rewards and coping with the emotional needs of the patient and family (Foxhall et al., 1990; McVicar 2003; Tyler and Ellison 1994).

The personal characteristics of the employee are another important aspect of workplace stress that must not be ignored. Personal factors such as personality and coping style can determine whether the employee will perceive certain work conditions as stressful (NIOSH, 1999). Additionally, the social environment or situational factors existing outside the workplace (e.g. family and friends) will also contribute to the perception of events as stressful. It is for these reasons that the NIOSH Model of Job Stress (1999) identifies individual and situational factors as mediators or buffers in the manifestation of stress (Figure 2). As such, individual differences can dictate whether a stressful situation has little or no effect on the individual or becomes heightened and requires resolution.

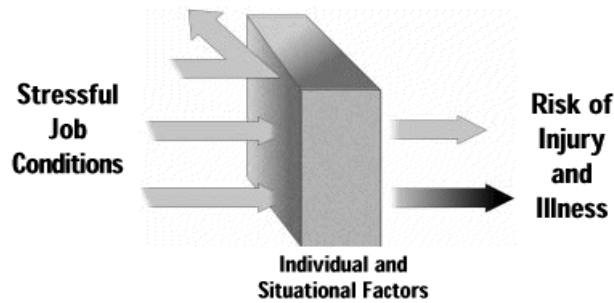


Figure 2. NIOSH Model of Job Stress

Reprinted from CDC NIOSH. Retrieved from <http://www.cdc.gov/niosh/docs/99-101/>

Traditional approaches to addressing workplace stress have focused solely on individual differences or worker characteristics and behaviors. This approach has led to strategies that rely on assisting employees in developing individual coping mechanisms. In doing so, healthcare systems have not acknowledged organizational contributions to the burden of stress experienced by nurses (Munn-Giddings et al., 2005). Occupational stress is an organizational problem; however, improvements in this area have been minimal. Evidence suggests that interventions that focus on organizational improvements as well as individual coping behaviors are the most effective (Blix et al., 1993; Cox, 1997; NIOSH, 1999). Therefore, a multi-level examination of the contributing factors and how they jointly impact the well-being of hospice nurses will lead to the most effective and sustainable strategies to reduce workplace stress.

2.4 STRESS AND COPING

Coping is defined as the cognitive and problem solving behaviors people employ to tolerate, minimize, or eliminate stress (Lazarus and Folkman, 1984). It is a complex interplay of thoughts and behaviors. Coping allows individuals to control and reduce the negative consequences of a stressful situation. Coping resources can be derived from both the personal and environmental. They refer to those reserves a person has that they draw upon to manage stressful encounters. When coping resources, no matter the type, are adequately matched to the stressor, outcomes are successfully controlled (Millikan et al., 2007). If, however, stressors exceed available resources, the aforementioned manifestations of stress can be observed. Coping strategies, on the other hand, refer to the behaviors/efforts that are put forth to combat the stress (Carver et al., 1989; Lazarus and Folkman, 1984). As an example, consider religion/spirituality which is a common coping resource. The actual coping strategy utilized would therefore be prayer or meditation or trusting that a higher power is in control.

While research regarding the identification of major stressors for hospice nurses is plentiful, few studies have examined the primary ways of coping for this group. Coping is an essential component in the understanding of workplace stress (Lazarus, 1999) and the resultant effects it can have on employees. Utilizing appropriate coping strategies can

influence the outcome of a perceived stressful event. These findings can have significant implications for the development of effective organizational interventions designed to combat workplace stress.

The work of Lazarus and Folkman (1984) on the Transactional Model of Stress and Coping offers a model of the process as a relational transaction between the person and environment. It highlights perceptions of the individual but recognizes the context within which the individual operates (Coyne and Lazarus, 1980; Lazarus and Folkman, 1984). This underscores the earlier identification of stress as a result of more than personal characteristics or behaviors. Instead, the focus is on both the person and his/her environment. According to the model, the individual's appraisal of the event as positive, irrelevant or stressful is the initial step. This decision is based on the individual's evaluation of the severity of the event and her susceptibility to stress. Second, the perceived amount of control he/she has over the event itself as well as potential resources to manage the event are evaluated. It is then up to the individual to decide which of those resources to draw upon as well as the coping strategy to manage the stressful event.

Researchers agree that coping mechanisms can be generally divided into two broad categories; problem-focused coping and emotional-focused coping (Gold and Thornton, 2001; Payne, 2001; Yancik, 1984). Problem-focused coping seeks to change the stressful event,

whereas emotional-focused coping is directed at changing the way one perceives the stressful situation. Another important distinction prevalent in the coping literature is that of active versus avoidant coping (Carver et al., 1993).

Active coping involves exerting effort of some kind to eliminate or minimize the stressful event. In active coping, individuals acknowledge the stressor and take measurable steps to resolve the issue. In contrast, avoidant coping relies on disengagement or denial. This type of coping results in dismissal of or an attempt to suppress the problem. Research suggests that problem-focused coping and active coping are most often associated with positive outcomes (Carver et al., 1989; Cohen, 1984; Holahan and Moos, 1987; Pina et al., 2008). These general coping styles (problem and emotion-focused vs. active and avoidant) have specific strategies that overlap one another. Ultimately, the chosen coping mechanism depends on the individual, his/her resources and the type of stressor. It is also not uncommon for a combination of these mechanisms to be used for any given stressor (Lazarus and Folkman, 1984).

A review of the literature reveals some trends in the specific ways of coping most utilized by nursing staff. Research has primarily focused on identifying coping strategies and categorizing them according to the coping styles described above. Planful problem solving is cited as the most widely used tactic (Celsowitz, 1989; Lambert et al., 2007; Payne, 2002). This

type of coping involves thinking about how to confront the stressor. Individuals will seek out all available information and begin to plan an appropriate course of action. In a cross-cultural comparison of stress and coping that included four countries, nurses identified utilizing planful problem solving as one of three primary ways of coping when faced with a potentially stressful event (Lambert et al., 2004). It is an analytical approach that requires an assessment of all possible options before a decision is made. The ultimate goal is to alter the stressor in some meaningful way so that the outcome is positive. Planful problem solving is an example of both active coping and problem-focused coping.

2.4.1 Spirituality

Positive reappraisal is an emotion-focused strategy in which an individual attempts to create positive meaning during a stressful encounter or reduce the magnitude of the stress thereby lessening the emotional load of the situation (Celsowitz, 1989; Payne, 2001). In a study of oncology nurses, the majority of the study sample reported using positive reappraisal when dealing with various stressors identified during the work day (Rodrigues and Chaves, 2008). Often, positive reappraisal is described as spiritual or religious and individuals focus on the

positive aspects of the situation and/or accept the situation as an opportunity for personal growth. The use of spirituality helps to reframe the adverse event into a positive situation accompanied by a greater sense of self-worth, commitment or appreciation. Moskowitz et al. (1996) consistently found that among AIDS caregivers positive reappraisal was associated with positive emotion and helped them to mitigate stress despite difficult situations. This is especially significant as it relates to hospice nursing because care and support are routinely provided to patients with life-limiting illnesses.

2.4.2 Social Support

Social support is well documented in the literature as a buffer or moderator of stress (Cohen et al., 1985). Having sufficient and adequate social support continues to be positively associated with better physical and mental health and overall well-being. In fact, Cassel (1976) posited that social support was a protective factor that reduced an individual's vulnerability to the harmful effects of stress on health. Social support can be provided through various networks such as family, friends, a community, social organizations or even coworkers. Coping resources that are available at both the individual and community levels may have direct health-enhancing effects and may also diminish the negative effects of stress (Glanz et al., 2002).

Work colleagues are therefore an important coping resource for to provide social support but typically in an informal manner (Coffey, 1999; Coyle et al., 2000; Kipping et al., 1998) as opposed to formal staff support groups for nurses. The support can be instrumental (tangible; relying on others to assist in planning/action), informational (seeking others for advice or guidance) or emotional (providing positive feedback or encouragement). One's perceived social support ultimately influences perceived control of the stressful encounter. Seeking social support is yet another example of problem-focused coping.

By contrast, the least used coping strategies among nurses are escape-avoidance and disengagement (Healy and McKay, 2000; Payne, 2002). Escape-avoidance is a coping strategy that is routinely relied upon when perceived control over a stressor is believed to be low (Carver et al., 1993). This strategy involves taking measures to avoid confronting the situation. Oftentimes, an individual will turn to food, sleep, alcohol, medication, drug use or the like in an attempt to avoid reality or deny existing circumstances. Disengagement is a term that refers to withdrawal or disassociation. Here an individual will attempt to minimize the significance of the stressor. Both escape-avoidance and disengagement are considered passive forms of coping. Also noteworthy is the association of escape-avoidance and disengagement coping strategies with higher levels of burnout among nurses. In fact, Healy and McKay (2000) found that although escape-avoidance coping was reported as being the least used coping strategy, in a

study of Australian nurses, it had the highest predictive value for mental distress and negative moods. This is consistent with the belief that the use of avoidant coping techniques typically results in maladaptive behaviors with increased negative emotions.

This information can and should be used in the development of organizational policies and approaches aimed at reducing workplace stress for hospice nurse. Folkman and Lazarus (1985) suggest that individuals will use both problem- and emotion-focused coping when dealing with any one stressor. Therefore, neither approach can be unequivocally associated with better or worse coping. However, understanding the most frequently used and most effective coping strategies for hospice nurses can be useful in education and training aimed at stress reduction as well as the development of programs that enhance the coping skills needed to manage stressful situations.

2.5 ORGANIZATIONAL APPROACHES

Given the negative consequences of stress on the well-being of hospice nurses, patient outcomes and organizational performance, it is in a manager's best interest to address stress levels in the workplace and keep them to a minimum. A healthy organization is one that has low rates of illness, injury, and disability in its workforce and is also competitive in the

marketplace (NIOSH, 1999). In order to achieve a healthy state, organizations must focus on better aligning job requirements with employee capabilities and maximizing the resources necessary to maintain quality performance. Likewise, it is imperative that organizations recognize their role in the relationship between stress and coping. How then are today's organizations addressing occupational stress?

2.5.1 Employee Assistance Programs (EAP)

The most common answer to workplace stress in the U.S. and abroad has been the development of employee assistance programs. Today more than 75% of all organizations in America have established an EAP (Employee Assistance Society of North America, 2007). EAP services are increasingly popular for larger companies. More than 92% of Fortune 500 companies report offering EAP services to their employees (Sciegaj et al., 2001). In general, EAPs provide short-term counseling services to employees and oftentimes their families on a referral basis. Featured as an employer funded resource, EAPs are directed at providing assistance to employees so that they remain productive in the workplace. EAPs proclaim that the benefits of their services are illustrated through significant improvement in work performance indicators: reductions in absenteeism, grievances, disciplinary actions, work accidents, staff turnover and

lateness (Macdonald et al., 1997). These improvements, according to self-reported data from EAP agencies, result in direct cost-saving benefits for the organization as well as greater job satisfaction for the employee. However, research to support these claims is sparse (Arthur, 2000; Carroll, 1996).

EAPs originated in the early 1940s as a rehabilitative service for alcohol and drug users to remain in the workforce. Since that time the scope has been expanded to also include mental health assessments, stress management services and health and wellness. EAPs are currently considered one of the main vehicles for occupational stress management and are evolving into providers of holistic well-being programs in the workplace (Kirk and Brown, 2003). A critical issue in the evaluation of the effectiveness of EAPs, however, is the fact that individuals who truly need and could benefit from these services may never seek or receive assistance. In the U.S., EAP referrals are typically made by management, which requires some skill in recognizing symptoms of stress and burnout in staff. Oftentimes, this results in delayed referrals, and the employee may already be in crisis mode (Cuthell, 2004). Additionally, participation in EAPs is largely voluntary and confidential so employers will not know if an employee has followed through with the referral. Some EAPs also rely on self-referrals. Self-referral patterns can be even more problematic due to stigma, concerns over confidentiality and denial.

Another and perhaps more significant challenge for EAPs is based on the framework and research discussed earlier. EAPs by design are largely focused on the individual. The bulk of criticism against the effectiveness of EAPs has been centered on this premise. EAPs emphasize identifying the problem and establishing solutions based upon individual resources to manage stress. They ignore the potential role of the workplace environment as a contributor to or cause of stress (Kirk and Brown, 2003; Roman, 1983). Treating individual symptoms and ignoring the complex interaction between the worker and the environment temporarily bandages a problem at the micro-level when it clearly originates from a macro-level source. A study of AT&T employees and the effectiveness of EAP services found that simplistic interventions to manage stress did not yield significant results and merely reduced the effects of stress rather than the presence of the actual stressor (Bunker, 1994). Individual approaches to stress reduction are beneficial, but having a combination of personal and organizational resources available is the most useful for achieving the greatest impact on workplace stress.

2.5.2 Wellness Programs

Other popular organizational solutions to stress are the development of workplace wellness programs and stress management training. Workplace wellness programs have proliferated

(Pelletier, 1999) and claim benefits similar to those of EAPs. One-third of employers reported having a wellness program, according to a recent MetLife Study (2009). In contrast to EAPs, workplace wellness programs do not provide counseling services. Instead, the focus is on linking employees with appropriate resources and emphasizing healthy lifestyles (e.g., workplace fitness groups, fitness education, information/awareness on health hazards or smoking cessation programs). In the case of wellness programs, stress reduction is an indirect by-product of participation. It is usually the physical effects of stress that are addressed through a wellness program. Therefore, the root causes of stress in the workplace or the development of personal and organizational resources to better cope with workplace stress are not explicitly addressed (Sperry, 1984). Again, at the center of this approach is the individual; the onus is on the individual to participate in this type of program and environmental factors are ignored.

2.5.3 Stress Management Training

Stress management training is another widely used methodology in the workplace. Nearly half of all large companies in the U.S. provide stress management training in some form to their employees (NIOSH, 1999). In stress management training employees are taught different

strategies like relaxation techniques, time management, meditation, proper fitness or proper nutrition. Edwards and Burnard (2003) found that these techniques were effective at reducing stress symptoms in mental health nurses but also found that these results were not sustainable. The two major disadvantages of stress management programs are: (1) the benefits are short-lived and (2) benefits focus on the worker and not the environment. Individual stress management programs are ineffective with respect to productivity and quality of work when organizational sources of stress are not addressed. In a review of stress management literature relevant to nursing, Jones and Johnston (2000) concluded that stress management programs were extremely limited in scope. Multi-level programs that augment individual level strategies with more structural attempts to reduce problematic elements of the work environment are needed (Martyn, 2000). This approach is the most direct way to reduce or eliminate stressors in the long term.

The literature on organizational interventions aimed at mitigating workplace stress in hospice care is much less robust in comparison to literature focused on specific stressors. Few studies focus on efforts implemented at the organizational level or those aimed at organizational change as they relate to stress. Most studies focus on identifying individual strategies employed by hospice nurses to better cope with the challenges inherent to their profession (Barnes, 2001; Celsowitz, 1989; Healy and McKay, 2000; Payne, 2001). In

particular, a large emphasis is placed on understanding the relationship between the most frequently used coping strategies and associated stress levels to determine potential effectiveness. Nonetheless, these studies echo the findings above, revealing a heavy use of stress management training for hospice nurses. Data on the utilization of EAP specifically for hospice workers were not found. Added to these services is typically the provision of staff support groups, staff memorial services and bereavement support to assist in the grieving process (DiTullio and MacDonald, 1999). Staff support groups are usually formal social networks designed to allow participants to openly discuss any problems they may be experiencing and debrief after particularly stressful events. Support groups are used to encourage playful problem solving, positive reinterpretation and personal growth (Sheehan and Forman, 1996). They also allow nurses to develop important relationships with other colleagues, which strengthens social support.

In order to be truly effective, interventions must be designed to enhance coping resources as well as coping strategies at both the personal and environmental level. This approach acknowledges the person-environment relationship and its influence as a stressor and ultimately the effective management of stress. DiTullio and MacDonald (1999) explain this process more fully using a hospice-specific stress model. This model is an expansion of Lazarus and Folkman's (1984) Transactional Model of Stress and Coping as well as Vachon's Life Model

for Occupational Stress (1987). Figure 3 is an adaptation of this model. The hospice nurse is faced with a myriad of demands at both the environmental and personal level. Situational factors such as grief, patient/family interactions and emotional strain also have an impact on the nurse. The perception of these demands as stressful is based upon an initial appraisal of the resources available to manage the stress. If resources are adequate, no stress is manifested. However, if resources are deemed inadequate, the manifestations of the stress at both the individual (burn-out or psychological distress) and organizational (poor performance or absenteeism) levels can be seen. The individual must then focus on ways to cope with the stress.

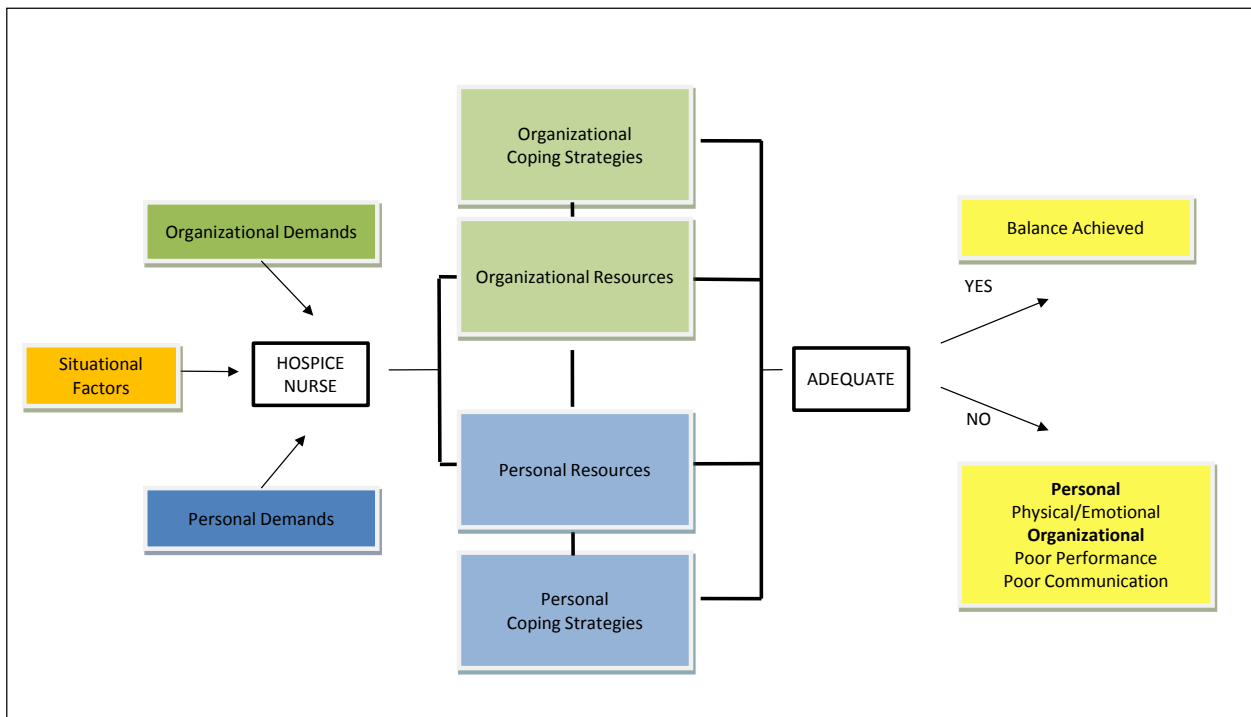


Figure 3. Hospice Stress Model

Adapted from DiTullio, M., and MacDonald, D. (1999). *American Journal of Hospice and Palliative Medicine*. 16(5):644.

Again, the hospice nurse can draw upon both personal coping mechanisms as well as those organizationally derived in order to attenuate the stress. Based upon this framework, hospice nurses are able to maintain normal, functional work-life balances if coping strategies and coping resources are adequate to meet demands. Therefore, evaluating available resources and effective strategies used by hospice nurses when faced with stressful events will provide direction for the design of more effective interventions and policies aimed at mitigating stress, which is the focus of this research.

3.0 METHODOLOGY

3.1 RESEARCH DESIGN AND RECRUITMENT

A cross-sectional design and convenience sampling were used to recruit participants for this dissertation. Cross-sectional studies are intended to capture the characteristics of a population at a specific point in time (Krueger, 1994). As such, cross-sectional designs are not able to confirm causal relationships. This approach is, however, appropriate in this research study given that the primary aims are to examine hospice nurse perceptions of coping.

Given the exploratory nature of this research and the focus on how nurses cope, qualitative methods were utilized to achieve the purpose of this study. Qualitative research provides valuable insights into complex issues (Maxwell, 2005). The goal of qualitative research is to produce information rich data from a specified sample (e.g., hospice nurses) that is able to speak to the research issues at hand. As such, the emphasis is not on generalizability but on depth and insight (Patton, 1990). Additionally, the results garnered from qualitative research are frequently used in the development of interventions. Focus groups were

specifically chosen as the primary methodology in order to more fully explore the experiences, perceptions and beliefs of hospice nurses surrounding the topic of interest. The hallmark of focus groups is their ability to elicit rich data and insights through natural group discussion (Krueger, 1994). This research also included a questionnaire to collect demographic information from participants and the 66-item Ways of Coping Questionnaire (Folkman and Lazarus, 1988) tool to measure the kinds and frequency of coping behaviors.

In order to be eligible for participation, individuals had to meet the following criteria: (1) employed as a Registered (RN) or Licensed Practical Nurse (LPN), (2) employed full-time, and (3) employed for a minimum of one year at the current hospice agency. Participants were recruited over a two-month period from January 2012 to March 2012. An introductory letter and recruitment flyer were sent to 16 hospices in the Charleston, SC area to be distributed to potential participants (Appendix A). This material was also sent via email to the President of the South Carolina chapter of the Hospice and Palliative Nurses Association (HPNA) to distribute to eligible members.

The introductory letter provided brief background on the research, research design and time commitment. Additionally, eligibility criteria and voluntary participation information were provided. Written informed consent was not necessary as the study was approved by University of Pittsburgh Institutional Review Board as exempt. Individuals were instructed to

contact the primary researcher by phone, email or mail if interested. Light refreshments were provided at each focus group session. Participants from each session were entered into a prize drawing for a \$25 Walmart card in appreciation of their time.

3.2 STUDY POPULATION

Of the 16 hospice agencies contacted, three agreed to distribute research information to staff.

These hospices (names omitted for anonymity) were:

- **Hospice A** – a ministry-based, non-profit hospice located in Mt. Pleasant, South Carolina
- **Hospice B** – a for-profit located in Wando, South Carolina, with three additional locations
- **Hospice C** – a for-profit agency located in Murrells Inlet, South Carolina; a part of larger system that operates three hospice brands in six states

Additionally, the members of the South Carolina HPNA, representing locations in Myrtle Beach, SC and Conway, SC, agreed to participate.

- **Hospice D** – a non-profit Catholic hospice
- **Hospice E** – a for-profit with 32 locations throughout the United States.

All of these hospices are community-based providing services in the patient's home and/or at a dedicated facility. In total four focus groups, consisting of 19 participants, were conducted. In

the first focus group at Hospice A there were four participants, in the second focus group at Hospice B there were four participants. The third focus group was comprised of the HPNA members and included six participants. In the final focus group at Hospice C there were five participants.

Each participant completed the demographic questionnaire and Ways of Coping tool. The majority of respondents were Caucasian, middle-aged (45-54yrs old) women working in hospice for at least five years. One male participated in the research study. Registered nurses comprised the majority (89.5%) of the respondents. It is worth noting that one participant was a Nurse Practitioner (NP), a category not specifically mentioned in the eligibility criteria. However, NPs are certified registered nurses who have completed graduate level education. This participant self-identified as a registered nurse based on her primary duties and was treated as such in the research study. In general, the majority of the participants had greater than 10 years of nursing experience but less than five years within hospice care.

3.3 RESEARCH METHODS

3.3.1 Demographic Questionnaire

The demographic questionnaire was developed by the primary researcher to obtain contextual information about each respondent. There were a total of ten items to complete (Appendix B). Marital status, gender, age and years of experience have been shown in previous studies to be predictors of coping styles so these items were specifically included to explore this relationship with the sample population (McVicar, 2003; Vachon, 1995; Yancik, 1984). The questionnaire was completed at the beginning of each focus group session in conjunction with the Ways of Coping questionnaire. Participants were instructed to not include their name.

3.3.2 Ways of Coping Questionnaire (WOCQ)

The WOCQ is a 66-item questionnaire derived from the original Ways of Coping Checklist developed by Lazarus and Folkman (1980). Based upon the Transactional Model of Stress and Coping, it is designed to measure the coping process through a range of behavioral and cognitive coping strategies an individual might use in a specific stressful episode. The WOCQ has been used previously in clinical settings and among nursing populations (Tully, 2005;

Wineman et al., 1994) in several research studies. However, literature on the use of the WOCQ specifically involving hospice nurses was limited.

The WOCQ tool can be self-administered or used in an interview setting. In this research study, the questionnaire was self-administered immediately prior to the focus group session. Respondents were asked to recall a stressful event directly involving the job within the last week and provide a brief written description of the encounter. They were then instructed to recall this encounter as they completed the 66 items. In general respondents completed the tool in roughly 15 minutes. Each item is measured on a 4-point Likert scale that measured how frequently they used each coping strategy (see Appendix B).

Eight subscales are included in the WOCQ used to describe coping strategies. These subscales can be categorized into two broad groups as problem-focused coping or emotion-focused coping (Gold & Thornton, 2001; Payne, 2001; Yancik, 1984). Table 2 below provides a description of the coping scales in the WOCQ tool. Problem-focused coping seeks to change the stressful event. An individual who utilizes problem-focused coping would take control of the situation, seek further information and evaluate the pros and cons. Emotional-focused coping is directed at changing the way one perceives the stressful situation. Examples of emotional-focused coping are praying, wishful thinking and distracting oneself.

Table 2 Description of Coping Domains

| | |
|---------------------------------|--|
| Confrontive | describes aggressive efforts to alter the situation and suggest some degree of hostility to risk taking. |
| Planful Problem Solving | describes deliberate problem-focused efforts to alter the situation, coupled with an analytic approach to solving the problem. |
| Seeking Social Support | describes efforts to seek informational support, tangible support and emotional support. |
| Self-Controlling | describes efforts to regulate one's feelings and actions. |
| Accepting Responsibility | acknowledge one's own role in the problem with a concomitant theme of trying to put things right. |
| Distancing | describes the cognitive efforts to detach oneself and to minimize the significance of the situation. |
| Escape-Avoidance | describes wishful thinking and behavioral efforts to escape or avoid the problem. Items on this scale contrast with those on the Distance scale, which suggest detachment. |
| Positive Reappraisal | describes efforts to create positive meaning by focusing on personal growth. It also has a religious dimension. |

Depending on the individual and the situation, either problem-focused or emotion-focused coping or a combination of both are used. Consensus on whether one is better than the other as an approach is neither definitive nor absolute. However, studies tend to find that problem-focused coping is typically most effective when the individual feels she has some level of control over the stressor, while emotion-focused coping is best suited for situations that are uncontrollable (Fang et al., 2006; Penley et al., 2002; Ruckolm and Viverais, 1983). Gender differences have been documented and suggest that women use more emotion-focused coping

than men (Billings and Moose, 1981). Table 3 provides a few examples of the items under each coping subscale that respondents are asked to rank in the WOCQ.

Table 3 WOCQ Item Examples

| | |
|--|--|
| <p>Confrontive</p> <ul style="list-style-type: none"> • Stood my ground • Took a chance | <p>Accepting Responsibility</p> <ul style="list-style-type: none"> • Criticized or lectured myself • I apologized |
| <p>Distancing</p> <ul style="list-style-type: none"> • Tried to forget • Made light of the situation | <p>Escape Avoidance</p> <ul style="list-style-type: none"> • Hoped for a miracle • Slept more than usual |
| <p>Self-Controlling</p> <ul style="list-style-type: none"> • Kept my feelings to myself • Tried not to act to hastily | <p>Planful Problem Solving</p> <ul style="list-style-type: none"> • I made a plan of action • Concentrated on the next step |
| <p>Seeking Social Support</p> <ul style="list-style-type: none"> • I asked for advice • Accepted sympathy from others | <p>Positive Reappraisal</p> <ul style="list-style-type: none"> • I prayed • Changed or grew as a person |

Two methods are used to score the WOCQ tool, raw and relative scoring. Raw scoring provides a summary of the extent to which each type of coping was used in a particular encounter. To calculate raw scores, the sum of the responses to the items in each of the eight scales is totaled. A higher score indicates that the person used the strategies described by that scale most in that stressful situation. A relative score is calculated by (a) computing the average item score for the items on a scale, (b) calculating the sum of the average item scale, and (c) dividing the average item score by the sum of the average item scores ($b/a = c$). This method controls for the unequal numbers of items within the scales and for individual differences in

response rates. A high relative score indicates that a person used those coping behaviors more often than they used other behaviors in coping with stressful event.

3.3.3 Focus Groups

Focus groups involve discussion with a selected group of individuals in an effort to understand their personal views and experiences about a specific topic. It is a particularly appropriate method for obtaining several perspectives about the same topic (Krueger, 1994). This method allows participants to openly discuss topics of interest in a natural environment where expressions and gestures can be observed. As such, focus groups are a widely used data collection tool in qualitative research. Given the goals of this research, conducting focus groups was determined to be an effective method for understanding how hospice nurses cope with stress and how the organization can provide support in ameliorating stress.

Focus groups were conducted between February and April 2012. The primary researcher facilitated each session. The focus groups were scheduled during the week according to respondent availability. Each session was conducted at the participant's agency, with the exception of the HPNA group which was held at a local hospital, through coordination with the Clinical Director or Administrator. Four focus groups with 19 participants (one male

[5.2%] and 18 females [94.7%]) were completed. In all but one focus group, participants were colleagues with other members in the group. Participants were asked to openly dialogue about topics related to the primary aims of the research. The primary researcher used an interview guide to facilitate the discussion (see Appendix C). This guide was developed based on the research aims and findings from the literature review. Initial questions were used as ice breakers to facilitate discussion. The remaining questions focused on obtaining more information on the perspectives, attitudes and experiences of the group. Participants were reminded that any names or other personally identifiable information would be redacted from the results. Additionally, participants were instructed to consider the focus group discussions confidential. The duration of the focus groups ranged from an hour to approximately an hour and a half. Each session was audio-recorded. Transcription of the data took place over three weeks by a professional transcriptionist. The primary researcher reviewed all transcriptions for accuracy; corrections were made as necessary.

3.4 DATA ANALYSIS

3.4.1 Qualitative Analysis

Immediately following each focus group general notes on the overall sessions were written by the primary investigator/facilitator. These notes were intended to capture the process and any unique observations as well any commentary that was of particular interest. An initial review of each tape was conducted making notes of any important findings. As noted above, each session was then transcribed; all names were redacted. The transcripts were reviewed by the primary investigator several times before content analysis was actually begun. Content analysis is a systematic way to describe and/or quantify phenomena. It allows the researcher to enhance the understanding of the data and test theory (Miles and Huberman, 1994; Patton, 1990; Weber, 1990). Furthermore, the process of content analysis enables the researcher to interpret and make sense of the data throughout the research, thereby making adjustments to codes and categories as new themes emerge.

Using directed content analysis, a categorization matrix was established based on the earlier review of literature (Hsieh and Shannon, 2005). The data were then coded and assigned to a category. However, the process was flexible in that any aspects of the data that did not fit

into the categorization matrix were used to generate new concepts or themes. As suggested by Miles and Huberman (1994), initial coding categories can be generated and then modified within the course of the analysis as new categories or themes emerge inductively. The resulting matrices were reviewed to evaluate potential relationship among the data.

A second reader was used to examine the clarity and consistency of the category assignments and assigned codes. In the event that differing categories emerged, the original coding was revisited and revised as needed. In some cases, the actual audio was reviewed to confirm that the original context or other information was not missing from the transcribed data. The data was continuously reviewed to ensure that all the salient themes were captured and to validate and revise codes.

3.4.2 Quantitative Analysis

Analysis was performed using Statistical Package for Social Sciences (SPSS) 20.0 (SPSS Inc, Chicago, IL) software. Descriptive statistics were computed for all of the socio-demographic variables in the questionnaire. In order to address the first research aim, “describe the primary ways of coping for hospice nurses,” a comparison of mean scores across each coping scale in the WOCQ was completed. Pearson Correlations were measured to explore a potential

association between nursing and hospice experience with coping strategy. *P*values of .05 were set for statistical significance.

3.4.3 Trustworthiness of Data

The research design and analytic strategies chosen for this study were carefully selected in an effort to ensure the trustworthiness of the data in accordance with Lincoln and Guba's (1985) evaluative criteria. These four criteria -- dependability, credibility, confirmability and transferability -- are addressed to enhance the rigor of the study. To establish dependability, each focus group was facilitated by the primary investigator using an interview guide. Agency nurses, nursing assistants and nurses working less than full-time and who were not employed at least a year at their agency were excluded from the research study. These exclusion criteria were chosen in an effort to include participants with diverse perspectives to address transferability. Multiple focus groups conducted in four different settings enhanced the validity and credibility of the findings. The use of the WOCQ in conjunction with the focus group sessions allowed for an evaluation of the consistency of the results and enables triangulation (Patton, 1990). Additionally, the follow-up notes from each session were compared with the transcripts to ensure accuracy. Original codes and themes were reviewed by a second reader

(and re-categorized when necessary) for conceptual agreement. Lastly, the themes that emerged were then linked back to direct quotes from the participants to ensure confirmability.

4.0 RESULTS

As discussed in the methodology section, study participants first completed a survey that included demographic questions and the Ways of Coping Questionnaire tool. The focus groups were conducted immediately following the completion of the survey. The following section presents the major findings from each of these processes.

4.1 SURVEY RESULTS

As shown in Table 4, the sample (n=19) for the study population included mostly middle-aged Caucasian women (45-54 years old). One male participated in the study. Low participation by males is consistent with national nursing statistics that indicate that approximately 5.8% of the nurse population in the U.S. are men (NHPCO, 2009). More than three-fourths (84.2%) of participants identified themselves as Caucasian, and 5.3% selected Black/African-American. Two participants declined to report their race/ethnic status. This distribution was consistent

with findings from a 2010 national survey of nurses, on which the RN population predominately (83%) identified as White, non-Hispanic (HRSA, 2010). The age of this study's population was generally older than the national average, with 47% of participants indicating they were 55 years old or greater while roughly 16% were younger than 44 years old. None of the respondents was younger than 25 years old.

Table 4 Participant Characteristics

| Variable | N | Percentages |
|------------------------|----------|--------------------|
| Age (yrs) | | |
| 25-34 | 1 | 5.3 |
| 35-44 | 2 | 10.5 |
| 45-54 | 7 | 36.7 |
| 55-64 | 7 | 36.8 |
| 65+ | 2 | 10.5 |
| Gender | | |
| Female | 18 | 94.7 |
| Male | 1 | 5.3 |
| Race/Ethnicity | | |
| White | 16 | 84.2 |
| Black/African American | 1 | 5.3 |
| Missing | 2 | 10.5 |

Table 5 displays the occupational status and years of experience among the study sample. All participants met the inclusion criteria. One participant self-identified as a Nurse Practitioner (NP), a category not specifically mentioned in the eligibility criteria. However, NPs are certified

registered nurses who have completed graduate level education. This participant is treated as a registered nurse in this analysis based on the fact that her primary duties were equivalent to those of an RN. On average, participants had more than ten years of experience in the nursing field. However, only 15.8% had the equivalent experience within the hospice/palliative care arena. Almost one-third (31.6%) had between six and nine years while most (52.6%) participants indicated having five years or less experience in hospice care.

Table 5 Occupation and Experience Characteristics

| Variable | N | Percentages |
|---|----------|--------------------|
| Occupation | | |
| Registered Nurse (RN) | 17 | 89.5 |
| Nurse Practitioner (NP) | 1 | 5.3 |
| Licensed Practical Nurse (LPN) | 1 | 5.3 |
| Number of Years as a Nurse | | |
| ≤ 5yrs | 2 | 10.5 |
| 6-9yrs | 3 | 15.8 |
| 10 yrs + | 14 | 73.7 |
| Number of Years as Hospice Nurse | | |
| ≤ 5yrs | 10 | 52.6 |
| 6-9yrs | 6 | 31.6 |
| 10 yrs + | 3 | 15.8 |

Mean scores on the WOCQ were also compared. Raw scores were calculated by totaling the score for each item on the scale to obtain an overall score. High raw scores indicate the person often used the behaviors described by that scale in coping with a stressful event. Relative scores, on the other hand, describe the proportion of effort represented for each type of coping. A high

relative score on a scale indicates that the person used those coping behaviors more often than they used other behaviors. Based on the relative scores, the most frequently used coping strategy was planful problem-solving ($M = .23$; $SD = .06$) followed by self-controlling ($M = .16$; $SD = .04$) and seeking social support ($M = .14$; $SD = .06$). The least commonly used was escape-avoidance ($M = .06$; $SD = .03$). Figure 4 displays the mean relative scores from the WOCQ tool.

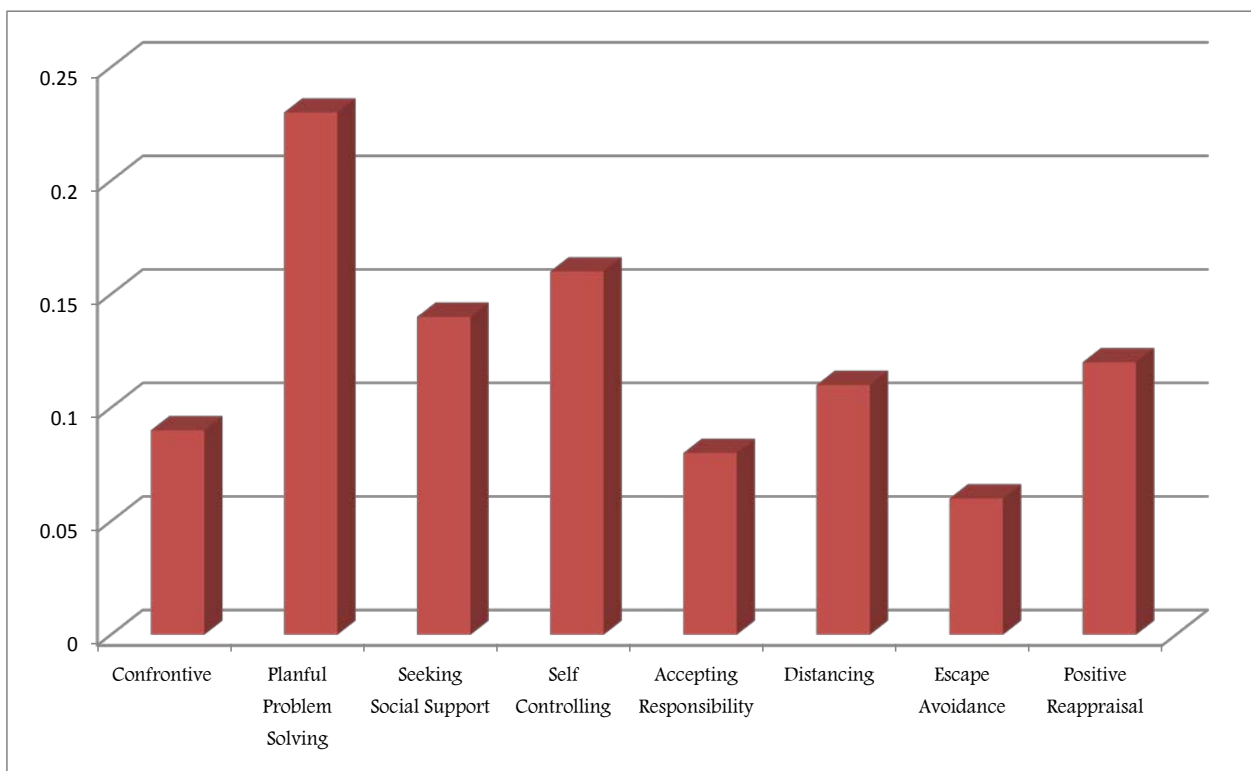


Figure 4 WOCQ Mean Relative Coping Scores

A comparison of mean raw scores and mean relative scores reveals an identical listing of the five most frequently used coping strategies. However, the rank order differs for each. Raw score reveals the following top five in descending order: positive reappraisal, planful problem solving, self-controlling, social support and distancing, whereas, the order for relative scores is

planful problem solving, self-controlling, social support, positive reappraisal and distancing. These results illustrate that respondents employ a mixture of problem focused and emotion focused coping strategies in times of distress. Table 6 provides the mean raw and relative scores for all the coping strategies organized by type of coping effort; (problem-focused or emotion-focused).

Table 6 Ways of Coping Mean Scores

| Coping Strategy | Mean^a | SD^a | Mean^b | SD^b |
|-------------------------------|-------------------------|-----------------------|-------------------------|-----------------------|
| Problem-Focused Coping | | | | |
| Confrontive | 4.78 | 2.52 | 0.09 | 0.06 |
| Planful Problem Solving | 11.57 | 3.06 | 0.23 | 0.06 |
| Seeking Social Support* | 8.15 | 4.52 | 0.14 | 0.61 |
| Emotion-Focused Coping | | | | |
| Self-Controlling | 10.31 | 3.43 | 0.16 | 0.04 |
| Accepting Responsibility | 3.15 | 2.75 | 0.08 | 0.64 |
| Distancing | 6.47 | 3.71 | 0.11 | 0.05 |
| Escape-Avoidance | 5.05 | 3.71 | 0.06 | 0.32 |
| Positive Reappraisal | 17.00 | 8.73 | 0.12 | 0.06 |

^a raw WOCQ scores

^b relative WOCQ scores

Pearson's correlation was used to explore the relationship between nursing and hospice experience and coping strategy. Relative scores from the WOCQ were used in this computation. No significant associations were found between any of the coping strategies and overall nursing experience. However, as seen in Table 7 below, there was a significant association between hospice nurse experience and two of the coping strategies: planful

problem solving and social support. There was a moderate negative correlation between planful problem solving and years of hospice experience ($r = -.497$ $p = .03$). Increased experience in the hospice setting was associated with lowered use of planful problem solving. There was a moderate positive correlation between social support and hospice experience ($r = .50$ $p = .02$). As hospice nursing experience increases there was a greater use of social support as a coping strategy.

Potential associations between the coping strategies were also explored (Table 7). Frequent use of positive reappraisal was strongly associated with less frequent use of confrontation ($r = -.573$) Likewise, self-controlling showed a moderate negative association with accepting responsibility ($r = -.493$) and escape-avoidance ($r = -.486$).

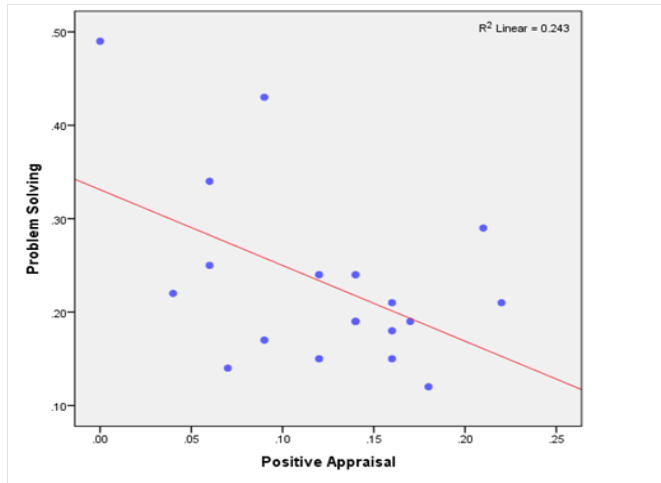
Table 7 Bivariate Correlation among Coping Strategies and Experience

| Variables | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|-----------------------------|---------------|---------------|--------------|---------------|-------|-------|------|------|------|----|
| 1. Confrontive | -- | | | | | | | | | |
| 2. Planful Problem Solving | .148 | -- | | | | | | | | |
| 3. Seeking Social Support | -.131 | -.392 | -- | | | | | | | |
| 4. Self-Controlling | .432 | .217 | -.341 | -- | | | | | | |
| 5. Accepting Responsibility | -.377 | -.482* | .09 | -.493* | -- | | | | | |
| 6. Distancing | -.396 | -.262 | -.348 | .029 | .039 | -- | | | | |
| 7. Escape-Avoidance | -.046 | -.468* | .204 | -.486* | .154 | .168 | -- | | | |
| 8. Positive Reappraisal | -.573* | -.493* | .054 | -.191 | .149 | .208 | .03 | -- | | |
| 9. # Yrs as a Nurse | -.17 | -.371 | .005 | .129 | -.007 | .228 | .157 | .403 | -- | |
| 10. # Yrs as Hospice Nurse | -.282 | -.497* | .502* | -.306 | .293 | -.194 | .311 | .435 | .328 | -- |

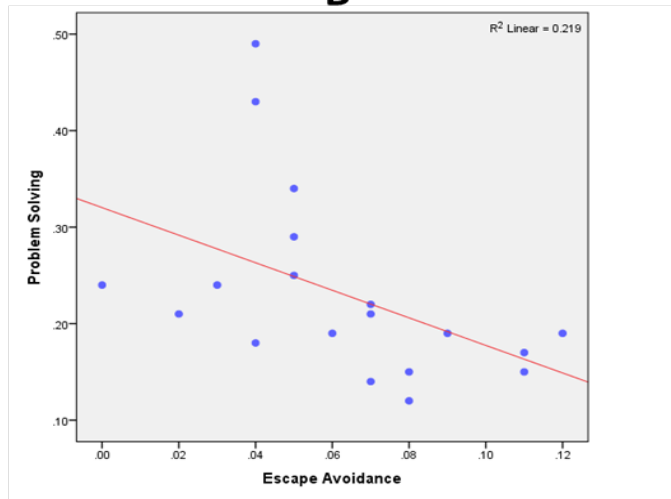
* $p < .05$

Planful problem solving was associated with three of the ten coping strategies: accepting responsibility ($r = -.482$), escape avoidance ($r = -.468$) and positive reappraisal ($r = -.493$). Figures 5a-c on the following page illustrates this relationship. Each of the scatterplots depicts an inverse relationship that suggests that as more planful problem solving is utilized the frequency of the other strategies is decreased.

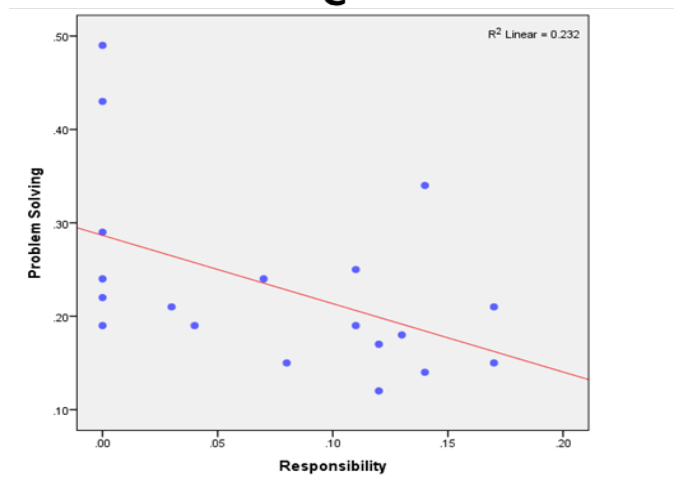
A



B



C



Figures 5a-c. Scatterplot Showing Relationship between Coping Strategies

4.2 FOCUS GROUP RESULTS

All of the focus group sessions were conducted at the participant's hospice agency with the exception of the HPNA group. This group included members of two hospice agencies and was therefore conducted at a local hospital. Focus group 1 included four registered nurses. Focus group 2 also included four registered nurses. Focus group 3 included six participants, one nurse practitioner, one licensed practical nurse and four registered nurses. The final focus group included five registered nurses. Participants in the focus groups expressed substantive comments ranging from why they chose a career in hospice to major stressors encountered at the workplace as well as their beliefs about how the organization can assist in preventing stress and aid in the coping process. Given the aims of the research study, a closer look at coping methods was conducted. Three major themes emerged in response to the exploration of the primary ways of coping among the group: (a) Social Support, (b) Humor and (c) Prayer/Meditation. The results of these discussions are summarized in the following text.

4.2.1 Why Hospice?

In an effort to bring clarity to the perspectives of the nurses on hospice and palliative care, they were initially asked to share what influenced or led them to a career in hospice nursing versus

other disciplines. A discussion of what they believed to be most rewarding about their jobs or rather “what made them stay” immediately followed this topic. Both topics were neutral, non-leading and non-threatening to allow for an open exchange among participants. The insights provided offered a glimpse into their shared commitment to the hospice philosophy as well as their attitudes toward death and dying.

4.2.1.1 The Motivation

The experiences that motivated nurses to pursue a career in hospice are categorized into four general themes: personal experience, mentor/faculty influence, dissatisfaction in a previous role and unemployment (see Table 8). The majority of the nurses shared stories that reflected their experiences caring for a loved one with a terminal illness. They described the impact that

Table 8 Reasons for Selecting Hospice

| Categories and Themes |
|---|
| Personal Experience |
| Caring for terminally ill family/friend |
| Having a family/friend use hospice |
| Mentor/Faculty Influence |
| Dissatisfaction in previous role |
| Stress/burnout |
| Needing closure |
| Ready for job change |
| Unemployment |

witnessing the dying process and/or their first interactions with hospice care had on their decision to choose nursing and ultimately hospice. One nurse articulated a very early experience in her childhood that helped shape her decision:

I was 15 with my mom – she had cancer. I was her caregiver and we didn't have hospice. I handled everything. I didn't have anyone...I found myself in hospital nursing but in the back of my mind and in my heart I wanted to try hospice.

As she continued to describe her transition from hospital nursing and management to hospice nursing, she commented on her desire to “let patients know they are not alone.” In her opinion, this experience also allowed her to better empathize with and care for her patients.

Another participant indicated that her experience with her pastor's mother was her first exposure to hospice. She was out of work and the family needed someone to sit with the mom.

During that time, she interacted with the nurses:

I got familiar with hospice and decided I liked going to the house and spending time with patients and stuff.

Interestingly enough, this nurse began working for that very hospice agency that left that early impression. There were several additional stories shared that illustrated the nurses' personal journey with loss and the impact it had on their desire to work in hospice. One nurse stated,

my husband had hospice when he passed away at 49. I saw how good they were and what they did for him. I said then, down the road that's what I want to do. I'm going to eventually do hospice.

In another group, one of the younger nurses shared that she went to school specifically to become a nurse.

probably mostly from my own personal history and my life of loss. Both with and without hospice care... It's so personal.

Another nurse explained her transition to hospice care from inpatient hospital work as one that was destined to happen. She explained,

I always felt compelled if we had a patient who was dying and they had no family...I would be the one to clock out and stay with the patient. I stayed many a night at that hospital. Then my mother went to hospice and I had that side into it. I felt a calling towards hospice many years before I actually took that step.

Other participants made the choice after years of experience in other areas that were either unsatisfying or did not fully meet their expectations or needs. One nurse indicated that it

it was difficult working in the hospital...being on my feet for twelve hours a day per shift.

The physical consequence of constant movement and long hours became too stressful and eventually necessitated a move to a less physically demanding field. Another nurse summed it up as follows:

I worked in the hospital setting for a little while and just in the field no matter what you did you didn't feel like it was enough or didn't find closure. You did not see the results of what you did.

This lack of closure or simply not knowing what ultimately happened to a patient was a theme that was highlighted on numerous occasions. Nurses felt that hospice enabled them to form relationships and connect with patients in a manner that was typically limited or constrained in other settings.

I think I'm in hospice nursing because it's the template for how all nursing should be. No barriers to relationships or if there are they are dealt with quickly because you don't have a lot of time.

According to these nurses, hospice offered more freedom, autonomy and support from a peer group than other types of nursing. It was equally important for participants to be able to provide support from the moment the patient began receiving hospice services until they passed on. They felt fulfilled in their roles when given the opportunity to “see things through.”

Other reasons given for choosing hospice revolved around influence from mentors or faculty. Several participants indicated that during nursing school they had the opportunity to shadow a hospice nurse, or a mentor/faculty member suggested that they would be a good fit for hospice based on their personality and skills. For instance, one nurse stated,

I did a rotation with the top line hospice. I rode with the nurse and I saw how on one street a patient can live in just the most glorious home and a supportive family but two streets over the next patient is by themselves, people are stealing their medications and the only person they have is the hospice nurse. That's when I decided that that was what I wanted to do.

In contrast, three of the participants indicated they simply “needed a job” or a change of pace and environment. After hearing the other nurses share their calling for hospice, one stated,

my story is nowhere near as dramatic. I just needed a job and knew where I wasn't going to work.”

Each of these nurses reported being ultimately happy with their decision but initially it was a matter of who was hiring and offering the best compensation.

4.2.1.2 The Rewards

It was clear that these nurses enjoyed their jobs for several reasons. No one was shy in offering an explanation for why they continued to work in hospice despite the repeated loss and grief.

In fact, in spite of the inherent stresses that were noted, all of the nurses expressed genuine satisfaction with their roles. In each group they recounted moments that reaffirmed their commitment to hospice care and their faith. In general, nurses most often mentioned being able to make a difference in the life of the patient or family as their biggest reward. However, equally important was the impact the patient had on their lives and the honor they felt from being a part of such a personal experience.

In particular, nurses valued the gratitude they received from family members. Being able to bring peace and comfort to the patient was deeply satisfying.

When somebody is really hurting and you go there and God gives you the right words, they tell you how much you have helped them. It makes it worth it. They make you feel that they couldn't have ever gotten through without you and its jut the love that the family shows to you. So just knowing that you gave them that little bit of support or made them feel good about something or just be there for that moment to make it just a little bit easier....this [hospice] is where you bring it to bear and I don't know of anything else that uses everything you have like this.

Another nurse shared that making the patient comfortable made her feel better. On those days when the family could not be there she got much satisfaction from being able to relieve the patients' pain, hold their hand and to simply sit with them. She stated,

Being able to help someone go in a more beautiful way makes the biggest difference.

They were also moved by being able to educate the patient and family on hospice care and death while witnessing the transition from resistance to acceptance.

I think the reward is from being able to teach somebody and help them understand what death is all about. And when somebody is really hurting and you go there and God gives you the right words, they tell you how much you have helped them, it makes it worth it.

Most often nurses encountered patients who were still in denial in the "hell no, not me phase" but after working with them those very same patients "could be at peace with everything," as one nurse described it. They hoped that they could always offer a "hand to hold and be a comfort" to each patient. When that goal was met it was positive reinforcement and validation.

With regard to the impact on the nurses' lives, nurses repeatedly reported that they believed they gained much more than they gave in the relationship. One nurse described this payback stating,

Not only do you make a difference to the patient and their family. But they make such a difference in our lives. They show you how to appreciate each second.

They discussed that they learned to look at life differently and to not fear death. Their faith is strengthened and their perspectives on the importance of family and friends are affirmed. All of these are direct benefits from their interactions with patients. One nurse explained it like this: *by watching them you realize what's most important in life...you see miracles happen.*

The nurses described these experiences as a catalyst for them to live their own lives with much more purpose and focus. In one group a participant noted

I learned how to appreciate life even more. I mean not that I didn't appreciate it from the beginning but we tend to take things for granted, but dealing with families at the end of life it helped me realize that every day, every moment is more special and it affirmed my relationship with Christ. It's a true blessing to be hospice nurse.

The final theme that emerged was the honor that nurses felt when they were allowed to share in a patient's final days. The nurses did not take for granted that they were being allowed to participate in an extremely private and personal matter.

It's a privilege to go into a person's home and an honor to hear their stories. I believe there's more laughter than tears. The telling of the stories is incredible. It's such a

blessing and sacred experience to be allowed into the privacy and intimacy of that family experience.

They described how rewarding it was to witness

loved ones and family members say I'm sorry and find closure at the very end.

These moments made everything worthwhile. It was clear through the anecdotal stories that while the groups could agree that there was stress associated with hospice work, the rewards reaffirmed why they continue to show up day after day.

4.2.2 Major Stressors

Participants were also asked to consider and discuss what they perceived to be the greatest sources of stress from working in the hospice environment. It was evident in each of the groups that nurses felt that the stress of hospice work was no more or less than in any other area but was definitely “different.” Most agreed that instead of physical stress it was emotional stress or mental fatigue that they typically experienced. Nurses’ beliefs surrounding workplace stress centered on challenges with the healthcare system, resources and interactions with the patient and family. There was also considerable discussion focused on achieving balance between work and personal demands.

4.2.2.1 System Challenges

In every group nurses reflected on the impact that navigating a complex healthcare system had on their day-to-day experiences. Layers of red tape, complicated structure and confusing policies were all cited as on-going issues. Many of the nurses expressed frustration about providing patients and families with information on service options or educating them on the nuisances of insurance coverage. One nurse described a current situation:

...you identify that there is a need and meanwhile the system doesn't quite address that need. Whether it's a loophole that your patient ends up in or there is no system for it that will address that need and so you are navigating through minimal options or seemingly unattractive options. It's you know, a healthcare tug of war between all the various agencies and the family and the money and the resources and the time and the emotions...

The system is very complex and makes it difficult for patients and family to understand policies and navigate what services they qualify for. Other nurses expressed similar feelings as they described having difficult conversations with patients and family to assist them with understanding insurance coverage and payment for care. Although the social worker and in some cases administrative staff were primarily responsible for these discussions, it was not uncommon for nurses to become involved as patients rarely made a distinction between these roles. One nurse explained that in her experience it is as if

the older generations are not aware that Medicare does not pay for nursing home beds. They automatically assume it, you know. They don't realize that it's so many rehab days

and that once you no longer qualify then you have to pay privately and that's like \$6,000 a month. I become angry because...stressed because I feel like the government is not up front and honest.

Ultimately, these difficult conversations were stressful for everyone, especially if the patient and/or the caregivers were not prepared for the financial burden or completely unaware of hospice regulations. These organizational constraints seemed to compound an already sensitive and tense circumstance. The nurses were keenly aware that they spent a great deal of time and energy attempting to resolve issues that did not involve direct patient care. As such, this became a source of stress because they would rather use that time and energy to care for the patient.

4.2.2.2 Limited Resources

In addition to the problems related to organizational structure nurses shared their concerns about adequate staffing and working in the field as well as access to appropriate medications. The limited and/or lack of personnel repeatedly surfaced as a source of stress. One participant commented that

the most stressful thing for me is when I feel like I don't have the resources to help with the needs of the patient or family. Resources can be personnel or material, you know, all kinds of things. If any of the pieces are missing you know, it hurts at the center...the patient.

They spoke of the structure of hospice, especially in non-inpatient settings, and the struggle to contact the appropriate person or receive timely responses. In one of the groups a nurse described how tiring it could be:

It was easier in the hospital in some respects because you have a resident everywhere and they can sign off on orders and stuff. Whereas like yesterday, I spent like the whole day just trying to get an order for medicine and that doctor didn't even acknowledge that I had asked for something.

When a patient is in crisis or something is urgently needed and

you're chasing orders and medicine it can be extremely stressful.

Another participant added that

it doesn't happen all the time but when it does happen it's a bitch and it's an all-day thing.

The impact of limited staffing was also felt in the frequency of being on-call and workload. Most of the nurses agreed that current staffing ratios left little time to recover from the day before. In one of the focus groups nurses described this stress as

the issue of enough time for regrouping or sleep or whatever. It's great when I work with a hospice that has a separate on-call staff and day staff. But in many hospices, especially the small ones, you need to take on-call.

Another nurse further explained that in addition to not having the time regroup it was the anxiety or "anticipation of being on call" that was the real stress. Preparing for the "unknown" was inherent in the hospice environment but it was never easy to accept. She explained,

the stressful part is not necessarily being on call. It's the anticipation of you worked all day and might get a phone call tonight and then have to work tomorrow. It's the anticipation of do you get to eat supper? Do you get to step in the shower before the phone rings?

Limited time to regroup was especially distressful following the loss of a patient. According to one nurse,

a lot of time, you know, we think about everybody but us. Put ourselves last and that part is very exhausting, especially when you lose someone. We have to take time to grieve ourselves. We don't have a lot of time do that.

They shared that they become quite close with patients and their families and they feel the loss too. Nurses appeared to be quite concerned about the inability to decompress and the impact this had mentally and emotionally. However, most acknowledged that they “push through” in order to focus on the next patient. Taking time off only shifts the burden to a co-worker and “placing that hardship on each other is not something we like to do” but with a lack of resources it happens all too often. Many felt that additional staffing could alleviate this pressure and reduce case load.

Not having the appropriate medications available to manage pain created similar distress and frustration. Several nurses shared stories to illustrate what many of them termed a “drug shortage” and how this negatively impacted the care they provided.

Taking people off the ventilator not to have the right medicine to keep them comfortable can be pretty horrible to watch, especially when you promise families something that you can't deliver on. We know what it should be like with the drugs that we usually have available so when you don't have the drugs available you see how it's going and you have to be calm around the family that doesn't know any difference.

It is a difficult situation because the nurses are aware that the process could (and should) be much better when the appropriate medicine is available. Many commented that not having resources on hand was one of the major differences they observed in working in hospice versus the hospital setting. They described that they frequently encounter scenarios where the medicine needed cannot be found in the community. One nurse mentioned that at that very moment she was waiting to hear from three different people about a medication that a patient urgently needed for pain. She indicated she had "100 similar stories about having meds accessible" when a patient is in a pain crisis and suddenly being faced with limited options.

4.2.2.3 Patient/Family Resistance

On several occasions the challenge of educating patients, caregivers and family about the philosophy and expectations of hospice resurfaced. Nurses felt that they were met with hostility or easily dismissed when patients did not fully understand that hospice was comfort care and not curative treatment.

It's the stress of having to educate people who sometimes are very resistant to hospice care...and going into people's homes where the families are not receptive and have not been educated on hospice.

In most cases they observed it was "family member more than patients" who had the most difficulty accepting the situation. Before they could care for the patient they needed to overcome the barrier with the family members. To illustrate that challenge one nurse described a situation to which all the nurses seemed to be able to relate.

The patient is 88 years old and accepting that they are at the end of their life. They say I'm ready to go. I've had a great life. Just let me go peacefully. But the family wants to take them to the hospital and treat them and give them IV fluids. Then the patient wants to please the family. It's sad to see. Very sad. And as nurses we just want to fix things...but it comes to a point where you have to accept reality that that's not what you're there for. There where I think a lot of hospice nurses get out of hospice care.

The majority of the nurses shared that in these instances the lack of understanding almost always resulted in a lack of support from the family which made caregiving in the absence of the nurse difficult. For example, one nurse stated she had a family that refused to give the patient her morphine because

they think that's going to get her addicted. They have no understanding that the patient is at the end of life. Addiction is not the concern.

Most believed that in the hospital they were able to control administering medication but in hospice they are forced to rely on the caregiver(s), and when there is resistance they are unable to provide optimal pain management. They shared the importance of educating and gaining

support from the family before they could provide complete care to the patient. The inability to do so was extremely frustrating and stressful as that was the ultimate goal of hospice.

4.2.2.4 Work-Life Balance

Balancing work demands with personal demands also emerged as a significant source of stress for several of the participants. The nurses felt that because of the unpredictable nature of hospice work it was difficult to actually “clock out.” Instead, they found themselves in a constant struggle to manage both, oftentimes to the detriment of their families or themselves.

One nurse said,

I get home at the end of the day and it's like ten o'clock at night. Haven't seen my kids since they – well, they get up and leave before I'm even up sometimes. I realize I focus so much on my patients I forget about myself or family.

A few of the other participants reported that having to be available at any given moment made it hard to make personal matters a priority. And for the same reasons noted above (limited staff) there was rarely an opportunity to take time out to focus on self-care. For nurses who were moms there was the added stress of caring for the family as well as the guilt that could accompany choosing personal over professional. One mother said,

As a new mom, I'm certainly learning how to [balance] so that when five o'clock comes I don't feel bad walking away.

Another nurse painted an even clearer picture.

...my daughter has her things like dance recitals and so forth. But there are many times where she is participating in these things but I'm on the phone with—still dealing with the job. It's very stressful. You can't focus and you know I don't think any of us ever cut off our phones at five pm.

Nurses acknowledged the consequences of tending to “at-home responsibilities” such as commitments with spouses, caring for children and household chores all while attempting to manage workplace stressors inherent in hospice culture. One nurse even admitted that it was not until the “insomnia set in” that she realized she was stressed and had not done a good job balancing things. All of the participants agreed that

it is a constant struggle to balance work life with personal life.

It was a something that no one could confidently say they had mastered.

4.2.3 Social Support

Nurses revealed that the most helpful and most frequently used coping mechanism was talking with and/or venting to others. In particular, members of each of the focus groups reported that they relied most heavily on their fellow co-workers in times of stress. While sharing with spouses or significant others was cited, many believed that their colleagues were the best outlet because they could speak freely about the situation. They understood the hospice environment

and could offer feedback. In fact, many expressed that it was often their colleagues who were the first to notice that they were stressed. One participant stated,

I think my co-workers understand without explaining a lot. The commonality; they know the language and they know the emotions.

Another nurse confessed,

when I get stressed out my co-worker will come to me and tell me to calm down and take a deep breath. I'm not saying anything but she can see the expression on my face...

Although the participants provided varying descriptions, it became clear through the discussions that most viewed the relationships with their co-workers as much more than a professional connection. For some, there was consensus that it was “more than a family” while others agreed that the relationship was

more personalized...not to the extent of a second family but we are able to share more with one another.

Another nurse commented that

...the relationship with my coworkers is 100% different than those I have had in a previous nurse role outside of hospice,

and around the room there were audible yeses and heads nodding in agreement. It was explained that the very nature of the work within hospice provided more of an opportunity to get to know one another and form meaningful relationships with colleagues.

Support from co-workers extended beyond fellow nurses. Quite a few participants shared that they frequently reached out to the on-staff chaplain or social worker when experiencing stress on the job. While these individuals were in place as support for patients and families, they became pseudo-counselors for their nurse colleagues. One participant said,

your chaplain and your social worker are always there and you can go and you know gain some support. We work as a team...that's the key to hospice.

This sentiment was highlighted as one nurse admitted,

I needed a little bit this morning. I needed someone to cry on and she [social worker] was there for me.

She went on to explain that the social worker validated her feelings and encouraged her to take time for herself. Within the hospice care team there was a

mutual relationship and we can reach out to each other.

It was interesting to note that in more than one focus group, members perceived their hospice to be “unique or different” with regard to the camaraderie shared with all their colleagues.

Participants also identified the Clinical Director and Nurse Supervisor as an integral part of the support team. A number of the participants commented that

management support makes a huge difference.

They could “*make or break the office,*” one participant added.

In one of the groups, it was mentioned that the Clinical Director provides encouragement and expects staff to take time-out to rejuvenate. Nurses truly felt they could always call on their director for advice in a difficult situation even if they were out in the field. Similarly, other participants expressed that simply knowing that

you have that support means a whole lot. That helps with some of the stress.

In the focus group of HPNA, members discussed at length that when managers had an open door policy or communicated openly with staff, it went a long way to reduce stress. According to one participant, there was

no big bad boss...anyone can come in and cry on her shoulder if necessary.

4.2.4 Humor

In contrast with survey results, the use of humor as a coping mechanism surfaced repeatedly in all the focus groups both among coworkers and with the patients for whom they provide care.

In one session, a participant spoke for the group saying,

We have a lot of humor. A lot.

Another chimed in to say,

That's true. We do try to use a lot of humor. At times I find we laugh a lot in the office when we are together.

Many admitted that humor allowed them to relax and was very therapeutic. There was consensus that given the nature of hospice,

laughter is a big part of the job, it helps to laugh and talk with co-workers.

One participant elaborated, adding

...sometimes it is black dark humor. The darker the humor, the funnier. It's quite interesting.

On more than one occasion participants displayed that humor in the session telling familiar jokes. One nurse explained that death is inevitable so everyone needs a plan because

no one gets out of here alive. Nobody...and I'm not talking about hospice.

The room erupted in laughter.

The nurses indicated that they shared jokes with patients because "it helps to laugh and it can be therapeutic." They also explained that the patients and their families were also known to share a joke or two to lighten the mood. On one occasion, a patient's son was telling jokes and the mother, the patient's primary caregiver, kept encouraging him to tell more. The nurse described it as "dark humor" that was good for both the mom and the patient. She recounted the story to the group saying,

He was very good. We all laughed. It's interesting how dark we get the more tired and fried we are. Here is the joke, "Did you know the Dead Dog Saloon burned down? Yep it did. It's been renamed The Cat's Return. Sign says CLOSED due to Ash Wednesday.

The group found this hilarious. According to them, the Dead Dog Saloon was a local favorite that everyone was familiar with and did indeed burn down a few months past. All of the participants spoke of the importance of laughing in spite of the heartache and pain and repeated loss that they witness on a daily basis. They believed that humor helped to take their minds off distressing thoughts or stressful situations, and it was not uncommon for them to use it in their practice for those very same reasons.

4.2.5 Prayer/Meditation

Throughout the general discussion with participants in each of the focus groups, the issue of spirituality surfaced. In every group, nurses mentioned the need for a strong faith or spiritual foundation and how both are tested and strengthened in their roles. Outsiders may perceive the job as morbid or depressing but nurses described it as an

honor, a sacred experience and a continuous affirmation of life.

This theme also came to light in the discussion focused specifically on coping.

On more than one occasion participants directly mentioned engaging in prayer both alone and with the patients under their care. One participant described it best this way:

I cry with them and talk to them and then when it's me by myself you know I have prayed and I have prayed with them. I pray in the car. And when something is really stressful then I pray. I'm praying all the time and reading devotional things.

Another indicated that she just takes time to

walk and pray. That's what I do. I think it may be probably the most important thing even.

Taking time for meditation or reflection seemed to be discussed interchangeably with the concept of prayer. A few discussed the benefit of the drive time to travel from one patient's home to another. One participant acknowledged that,

during the long commute there is time to think and if you give yourself that time you can decompress. I find that very therapeutic.

Others indicated that they carve out time specifically to meditate or to be alone with nature to regroup and reflect. An overwhelming majority perceived prayer/spirituality to be an essential part of their coping process. One nurse shared that on occasion she is not fully aware of the stress and will find herself emotional and her spirituality will help her through.

I do find myself sometimes just driving along and I might start crying. I might start praying. It takes more of a toll than I think we know. You have to have a good spiritual base to deal with all.

Another nurse added,

you have also got that spiritual support sort of thing within your group

as she referenced the other nurses and members of the care team. She further elaborated stating,

We had a chaplain not too long ago that we could call up and before you could even get the words out of your mouth he would start praying.

4.2.6 Organizational Resources

4.2.6.1 Existing Resources

When participants were asked about the availability of formal programs or services at their workplace to assist in coping, the responses were almost unanimous. Most of the agencies, with the exception of one, did not provide any formal assistance to employees. One nurse commented that, the extent of their activities was

doing a wreath when a patient passed away to honor their memory. We pick out a color of ribbon that is significant to the patient.

It was their opportunity to grieve as a team over the loss. Another added that

we try to have parties every now and then; even if it is just pizza and we have a wonderful post-holiday party to unwind.

Others explained that while they did not have formal activities, their manager did things to reward them. They made certain to mention that they believed she coordinated these things on

her own accord (i.e. without higher leadership support or input) to let them know they were appreciated. She would plan

team building exercises or you know we had champagne the other morning...just nice little things. She does her best.

The more seasoned nurses provided a historical perspective stating that,

...we used to have programs. Many years ago Sister Dyson sent everybody to therapy. We had a group that went to the river to walk and let it all out therapy kinda thing. Then they just stopped. In the olden days of hospice, I'm talking 1986, most hospices had weekly support groups for their staff that was facilitated by someone outside of hospice and no one from management was allowed to attend. It was really truly for the clinical staff. You didn't always make it every week. But as hospice grew and went from being sort of a grassroots family to more of a business that was one of the first things that hospice gave up and said they couldn't afford to do for their staff any more.*

*name changed for anonymity

Nurses from the agencies that did offer some type of resources provided both positive and negative feedback. Participants from one agency readily admitted that they felt fortunate regarding the resources available to them especially after hearing the other participants' discussion. Their agency, the only national agency participating in the study, held quarterly meetings. One nurse described those meetings as "non-management attended" and explained that,

they can go in any direction. We also have an EAP program since we are a coast to coast business that we can call and access for a long list of issues. We have a care line if it's a corporate compliance issue or a complaint or compliment. So we have a lot of avenues.

Coincidentally, this was the only mention of EAP in any of the focus groups. On the other hand, a participant from the second agency expressed concern about the type of assistance and usefulness of the resources they were provided. At this particular hospice, bereavement workshops or memorial services were held. The nurses noted that

Sometimes that isn't what we need to really decompress or to have some satisfaction, you know. I think they are trying to show respect and not become desensitized because I know that can happen but to me that doesn't have the therapeutic value. I don't want to submerge myself into this very somber mode of reflection.

4.2.6.2 Recommended Resources

In addition to speaking about the organizational resources that were currently available each group spoke candidly about resources they believe could be provided to assist in the coping process. A number of the participants indicated that they would welcome staff support groups that were informal. The nurses specifically spoke of having support groups for clinical staff

facilitated by someone outside of hospice or rather no one from management

that would be confidential. Another participant clarified explaining

it should be someone outside but that understands hospice.

They also suggested that these groups should be voluntary and that back-up staff should be brought in so that they did not feel guilty for attending. Another nurse suggested a support group patterned after a 12-step program to strengthen existing coping skills and gain new

ones. Instead of a group structure one nurse suggested having an individual available with whom to talk one-on-one, someone who would be “objective and not in the organization.” She and the other nurses stressed that this person would need to be familiar with hospice to be the most effective. Another participant recalled that her sister who works in suicide prevention is able to see a counselor every two weeks. She offered that as a potential solution. She shared this:

...she asked me when I see my counselor. You have a counselor, right? You are dealing with death and dying all the time. I said, no, I don't. She said, "oh, in Germany if you are in any kind of stressful job you will get counseling." I think that could be good. Otherwise we have to seek out our own counseling.

There was consensus that having someone to talk to whether on-site or via telephone would be beneficial on a particularly stressful or painful day or when they experienced loss. Many wondered why this was not a resource that was already available considering the circumstances of their jobs.

Outside of the support groups and talk therapy recommendations nurses suggested more social activities and group exercise opportunities. One nurse was excited to offer

more parties, more food and more wine

to de-stress with co-workers as a potential solution. There were nodding heads and smiles from the group. In contrast, another nurses' suggestion was to offer a yoga class but the older nurses

in the rooms remained silent. The group then burst into laughter. None of the older nurses were interested in that method and it was clear.

The remaining suggestions were administrative changes to eliminate stress altogether. Nurses wanted to see more staff to alleviate the pressure of on-call days. They wanted management to be open and communicate financial issues that would restrict what they are able to provide to the patient. It was explained that

...some stress comes from management...it's hard when you are the nurse and you know a patient needs something but you have to watch your dollars. You talk to your team members and they agree but you have management saying, well, we can do this or we do this but not this. But they aren't there to see the patient.

The nurses felt that improving communication and including them in discussions about the financial climate of the agency would go a long way to avoid added stress. Some commented that while they still provide good care the philosophy of hospice has been diluted due to:

the whole business side of it and management sometimes loses the perspective of what it's about.

That is why good leadership was highly regarded in all of the groups.

5.0 DISCUSSION

This study was conducted to explore hospice nurse perspectives of the most effective ways to cope with workplace stress. The collective responses of the participants revealed that nurses use a variety of strategies that combine both problem and emotion focused coping. However, seeking social support, humor and prayer/meditation are considered the most effective coping mechanisms. Focus group discussions also revealed hospice nurse ideas for how organizations could assist in the coping process. In addition to these results, nurses discussed their motivation for choosing a career in hospice and what they perceived to be most rewarding about the role.

Consistent with the hospice literature (Cohen, et al., 1983, 1985; Kulbe, 2001), social support was shown to be a major factor in the coping process for these nurses. They repeatedly discussed the availability and importance of support from fellow nurses, management and the chaplain or social worker on their team. They cited multiple examples of being able to vent to colleagues without feeling judged or incompetent. Similarly, the survey results illustrated that when faced with a stressful situation, seeking social support was the second most frequently

used coping strategy. It was also noted that having support within the team went a long way in efforts to decompress and keep going. Previous studies have suggested that belonging to an effective team and adequate social support are vital to the well-being and survival of employees within the hospice/palliative care setting (Cohen, 1985; Vachon, 1987a). Support from management and nurse leadership was mentioned numerous times as providing positive reinforcement and reassurance on job performance. Based on the discussions, it appears that management support, or the perception thereof, was viewed by nurses as a potential buffer or protective factor against workplace stress.

An unexpected finding was the significance of humor in the coping process. None of the hospice literature reviewed specifically cited humor as a coping mechanism. However, the importance of laughter was underscored time and time again in each of the focus group sessions in this study. The use of humor was immediately evident in the focus group sessions themselves as the participants frequently joked with one another. Participants indicated that laughter was key, especially in light of the pain, heartache and death that they encountered on a daily basis. Humor has been well documented in the general coping literature as being effective in facilitating more positive cognitive appraisal (Davidhizer & Shearer, 1996; Wooten, 1996).

The WOCQ does not specifically capture humor as a coping subscale so comparisons between the focus group discussions and survey results are limited. However, positive reappraisal, distancing and escape-avoidance are measured. Humor has been categorized as a domain in each of these, which are all aspects of emotional-focused coping. Although not indicated as the most frequently used styles, positive reappraisal and distancing are among the top five styles utilized. Escape-avoidance was the least documented style. Based on the dialogue in these groups, humor appears to be used most often as an attempt to reframe a stressful event and attenuate negative feelings versus efforts to avoid the problem. Even in the use of humor with patients this premise holds true. Nurses commented that the telling of jokes was therapeutic; giving both them and the patient/family a chance to “exhale” and take their minds off such emotionally charged situations. This may suggest that humor is inferred from within these domains. Findings of this study, suggest that humor is a powerful coping strategy that should be measured directly in WOCQ and other coping measurement tools to further evaluate its utilization in the stress and coping process.

Given the emphasis on spiritual care within hospice it is no surprise that nurses had strong beliefs about the benefits of prayer/meditation in the coping process. The central role of spirituality in hospice/palliative care has been documented (Celsowitz, 1989; Duffy, 1996; Moskowitz et al., 1996). Consistent with these findings, the study sample in this research

expressed that assisting patients in the dying process consistently reaffirmed or strengthened their spirituality. In fact, contrary to what many believe, the nurses spoke about how calming and rewarding it was to witness such a sacred moment (i.e. death). Interestingly, many of the nurses seemed to consider this calming and a form of coping or rebalancing amidst times of stress. This suggests that in accordance with the Transactional Model of Stress and Coping (Lazarus and Folkman, 1984), faith/spirituality plays an important role at both the initial appraisal stage and in the assessment of coping resources. Perhaps this could then potentially explain why this theme was pervasive in the focus groups as a successful way to mediate stress.

The WOCQ tool includes two religious items, “I found new faith” and “I prayed,” both included in the positive reappraisal subscale. Positive reappraisal was among the five most frequently used coping mechanisms in the survey results. Results of the focus group discussions support this, as spirituality emerged among the three most frequently used/effective mechanism. Not only was spirituality viewed as a significant personal coping resource, nurses also drew upon it in their support and care of patients and family. Also noteworthy is the fact that prayer and meditation seemed to be akin to personal reflection among participants, and the terms were used interchangeably. This makes sense in the context of the WOCQ in that the domain positive reappraisal encompasses all of these strategies.

As a whole, the results of the quantitative analysis validated the sentiments expressed by nurses in the focus group sessions. Mean relative scores on the WOCQ demonstrated that nurses used planful problem solving, self-controlling, social support, positive reappraisal and distancing more often than they used other behaviors. Similarly, social support and positive reappraisal were regularly cited in the focus groups. The absence or low incidence of planful problem solving, distancing and self-control from the discussions may be due to contextual differences. In the survey, nurses were asked to specifically consider a stressful workplace encounter. The focus group discussions discussed nurses coping strategies across the spectrum of workplace stressors that nurses perceived as threatening. For planful problem solving, it is highly likely that in general nurses feel that they have little control over these aspects so the focus is placed on changing the perception or reaction rather solving the problem. Nurses who rated distancing or self-controlling highest on the WOCQ described encounters that were confrontational with either the patient or a caregiver as their frame of reference. The focus group discussions highlighted challenges with resistant patients and family, but no examples of confrontations were cited. This may explain the absence of these domains. However, follow-up interviews with participants to better understand these differing results are warranted.

It was expected that there would be stronger associations demonstrated between more of the coping strategies and experience. However, the moderate associations found between

hospice nurse experience and social support and planful problem solving suggest the need for future research to further explore these relationships. It makes sense that social support was positively associated with more experience as a hospice nurse. This is likely a result of more seasoned nurses having stronger relationships with colleagues as well as having formed more networks than newer nurses. Similarly, the negative correlation between hospice experience and planful problem solving indicates that more experienced nurses do not focus on resolving every challenge. Perhaps these nurses accept death as a natural process and have likely accepted that other stressors are simply inherent to working conditions. Therefore, less energy is placed on solving problems beyond their control. In contrast, less experienced nurses are still learning to navigate the system and are focused on ways to resolve barriers. This echoes one nurse's comments that it was her belief that "nurses leave hospice due to their inability to fix things." Similarly, the inverse relationship seen between planful problem solving and positive reappraisal may likely be a result of nurses reframing or relying on a higher power for stressful events that they have little to no control over. Alternatively, it is reasonable to assume that the relationship between nurse and hospice experience and coping strategies is real but small. Due to the limited sample size and low power, significant associations are difficult to detect.

An additional aim of this study was to explore nurse attitudes about workplace programs to assist in the coping process. Both positive and negative feedback was received

regarding the availability and adequacy of organizational resources. However, the majority of respondents felt that organizational resources were not adequate and could be strengthened. In contrast to the literature (DiTullio & MacDonald, 1999), several participants expressed concern that there were actually no established programs at their agency. Others perceived that the activities that were available did little to actually assist in the coping process. Two nurses identified that EAPs were available at their agency. They spoke positively about this as a resource but did not comment on whether it was frequently utilized or considered effective among their colleagues. Additional probing questions to explore the specific usage of EAPs were not pursued. Other activities (e.g., wreath building and memorial services) fit into the realm of grief support groups, which nurses indicated were sufficient to acknowledge the loss of patients but unnecessary and inadequate as a resource to assist with coping, a challenge highlighted in other studies (Currier et al., 2008; Harvey, 1992). Essentially, these studies concluded that bereavement and support groups are narrowly focused and seldom result in sustainable coping efforts. This underscores the need for interventions that bolster coping resources for nurses rather than a singular focus on individual feelings and efforts. This becomes increasingly problematic when applied universally to all griever versus those at greater risk for complications. Additionally, as evidenced by focus group results, nurses clearly

indicate that death/dying is not a primary source of stress; therefore, a resource that emphasizes this process is likely misguided and undesirable for this group.

Although exploring the motivations for becoming a hospice nurse and the stressors and rewards of that role were not among the purposes of this study, understanding these dimensions has significant implications for the development of organizational resources and policy changes. For instance, several of the nurses described their personal connection with death and/or hospice care that attracted them to positions in hospice. This personal connection may function to strengthen these nurses' resolve and commitment to the philosophy of hospice. Additionally, the strong spiritual ties that were reported seemed to translate into significant rewards when nurses were able to assist patients and family in accepting the dying process as next phase of life. By extension, these nurses may then be somewhat protected from what most would consider "stressful" since their initial appraisal of this work is positive. This also suggests that interventions that focus on loss or grief are not appropriate for this population. Instead interventions that assist nurses with building strong supportive relationships with colleagues should be considered. New hospice nurses could benefit from being partnered with seasoned nurses as not only a training method but in order to further develop support networks for newer nurses. Acknowledging that the greatest stressors for this study population were related to organizational constraints (call schedules, staffing, limited resources, etc.) also presents an

opportunity to modify practice standards or policies to reduce or eliminate stress that are born from the business side of hospice.

While the above discussion illustrates that nurses are finding ways to cope, it also highlights an opportunity for agencies to explore ways to establish interventions that build upon the effective coping strategies identified by the staff. It appears that historically, workplace programs were available at many of the agencies, but as hospice grew, support of this type was eliminated. The hospice nurses in this study reported that managers did what they could to provide some form of support, but efforts were hampered by a lack of resources or support from agency leadership. Ultimately, nurses believed that there was a need for formal organizational resources and expressed a desire to participate in these options should they be made available.

5.1 LIMITATIONS OF THE STUDY

Although this research furthers our understanding of the coping process by capturing the unique perspectives of hospice nurses, some limitations should be noted. First, qualitative research is not generalizable. The sample cannot be considered representative of all hospice nurses. There may also be substantial differences in nurses who chose to participate versus

those nurses who declined. Differences between the hospice agencies that declined participation and the agencies included in the study may also be significant. The race/ethnic distribution of the study sample may also differ from that of other geographic regions. Therefore, transferring results to other settings or contexts should be done with careful consideration. However, it should be noted that generalizability was not the intent of the research.

Additionally, because of the cross-sectional nature of the research causal relationships cannot be inferred. The limited number of participants ($n=19$) is not adequate to obtain any statistically significant associations among variables of interest in the quantitative analysis difficult and may have decreased the variability in viewpoints in the focus groups. The use of self-reported measures can mean that individuals provide answers based on group influence or that they assume are desirable. There is the desire to provide responses that may please other group members or the facilitator, which may introduce some levels of bias.

5.2 FUTURE RESEARCH

Additional research that examines the relationship between nurse experience and coping mechanisms is needed. It remains unclear how hospice nurse experience may predict

coping strategies. It is also quite possible that certain demographic characteristics may predict coping strategies. Understanding these relationships may assist in targeting interventions for those nurses that are having difficulty coping with job stress. Additional research on the role of humor as a coping strategy among hospice nurses is also warranted. Given the feedback on the importance and perceived effectiveness of using humor both among colleagues and with patients it is clear that this is a concept that needs further exploration. The results may suggest the need to train/educate nurses on the use of humor in patient care. Additionally, this can provide further guidance for developing and refining tools that measure humor as a coping strategy. More qualitative research that explores hospice nurse perceptions about and experiences specifically with EAP would also be worthwhile since it was not explored in-depth within this study. The results could provide a better understanding on the availability and efficacy of EAP services. Perhaps this is a service that should be offered at every agency or perhaps funding spent in this area can be repurposed for interventions that better address work conditions. In-depth interviews to explore the absence of planful problem solving, distancing and self-controlling from the focus group discussions given their prominence in the WOCQ results is warranted. Comparison studies with larger study populations would also be beneficial. Expanding recruitment efforts to include additional geographic region to capture additional RNs and LPNs may increase the sample size to allow for additional statistical analysis

to be performed. Lastly, research that compares the availability and adequacy of coping resources for hospices across different settings (e.g., home hospice vs. inpatient hospice or non-profit vs. profit status) may also be worthwhile given the contrasting results of this study. There may be opportunities to recommend standard interventions for hospice programs.

6.0 CONCLUSION

Hospice nurses are critical to the future growth and success of hospice care. Nurses are considered an integral member of the care team and represent the primary source of professional services. Unfortunately, as it relates to staffing, nursing has been unable to match the tremendous growth seen in end-of-life care over the last decade. The nurse shortage has made recruiting and retaining hospice nurses a challenge. Studies have identified workplace stress as one of the factors contributing to this dilemma.

This research was conducted to examine the ways in which hospice nurses cope with workplace stress and understand their beliefs on which coping strategies are most effective. We explored the use of social support and the availability of workplace programs to assist in the coping process. Lastly, we focused on understanding nurse perspectives on how organizations can offer resources to bolster coping efforts. Given the evidence that links workplace stress to poor overall health (mental and physical) as well as lower job performance and job satisfaction

this research was intended to offer recommendations to provide adequate support for hospice nurses and expand the existing coping literature for this population.

Registered nurses working full-time for at least a year in hospice/palliative care were recruited over a three-month period to participate in focus group sessions. Prior to the start of each focus group participants completed the Ways of Coping Questionnaire as well as items designed to collect demographic information. A total of four focus groups were held with 19 nurses from the Charleston and Murrels Inlet, South Carolina areas.

The exploratory nature of this study provides important insight into the coping process for hospice nurses. Based on the findings, there is a lack of robust organizational resources available for hospice nurses to draw upon to cope with workplace stress. Nurses reported disparate interventions across hospice settings and expressed that these programs were inadequate and primarily ineffective. Hospice nurses employ a variety of coping strategies to manage stress. However, they perceived prayer, social support and humor to be the most effective coping strategies. This information should be used to inform targeted interventions and policy changes within hospice care. WOCQ results were primarily consistent with focus group results. However, planful problem solving, escape avoidance and distancing did not emerge as strategies frequently used among nurses in the focus group discussions as they did in the WOCQ results. This suggests a need to explore these strategies more fully with nurses to

understand how they are operationalized in their coping on a daily basis. Lastly, the presence of significant associations between experience as a hospice nurse and frequency of specific coping strategies could also be fruitful for future research.

Research findings demonstrate that nurses are keenly aware of job stress (typically compounded by personal stress) and its effects on their well-being but overall find their jobs extremely rewarding. The results also illustrate that contrary to expectations, hospice nurses do not feel undue stress from the death/dying they encounter but rather from working conditions (e.g. limited resources, call schedules and patient/family interactions) and attempting to balance work and personal demands. Most importantly, despite the absence of workplace programs, hospice nurses have established ways of coping that incorporate both problem- and emotion-focused strategies in an effort to achieve balance but welcome workplace resources to further these efforts. Many of the nurses acknowledged that they have yet to find that balance or master the coping process. It is therefore essential that organizations develop interventions to assist in the coping process (DiTullio and MacDonald, 1999; Vachon, 1985) and maximize the availability of resources. By extension, interventions that build upon the strategies cited by hospice nurses will be most effective and achieve sustainable results.

6.1 RECOMMENDATIONS

In general organizations should work to strengthen coping resources by developing workplace programs that build upon strategies that hospice nurses consider most effective (i.e. social support, humor, prayer/meditation). Support groups, peer mentoring and team building are a few examples of interventions that can incorporate these strategies. Nurses in this study provided specific recommendations they felt would be beneficial. The following summarizes this feedback.

- Meet with hospice nurses to understand the unique workplace stressors of their staff;
- Initiate efforts to reduce/eliminate those identified work stressors;
- Collaborate with nursing staff to develop workplace interventions best suited for enhancing coping efforts;
- Ensure that interventions are facilitated by individuals not associated with the hospice agency but knowledgeable about the hospice environment; and
- Create a policy for voluntary participation in workplace programs unless a serious concern has been identified, at which time a supervisor can recommend and/or mandate participation.

6.2 PUBLIC HEALTH SIGNIFICANCE

In the U.S., adults spend a considerable amount of time (nearly half their waking lives) at work. It is widely accepted that our work environments can influence overall health. Unfortunately, more than 30% of American workers have indicated that they experience high levels of on the job stress (NIOSH, 1999; OSHA, 2000). Occupational stress has been linked with numerous health problems such as cardiovascular disease, workplace injuries and musculoskeletal disorders to name a few. In addition to the health consequences, we now know that job satisfaction and job performance are negatively impacted by stress.

The healthcare arena has been specifically identified as having higher levels of stress in comparison to other industries. While opinion is mixed regarding whether hospice nurses experience greater levels of stress when compared to nurses in other specialties, there is consensus that the nature of the job is inherently stressful. Therefore, a greater understanding of how maintaining the expectations of hospice care can create a stressful environment for hospice nurses is imperative to the future success of hospice. Similarly, an awareness of the complex interplay between personal characteristics and the work environment is vital in establishing effective interventions for hospice nurses.

The public health significance of the issue is therefore two-fold. First, one of the major tenets of public health is health promotion and disease prevention. We must protect the well-being of hospice nurses. If nurses are under stress for long periods without effective coping methods, they may become more fatigued than they realize, affecting not only their occupational life but also their nursing competencies (Lee, Chen, and Lin, 2005). Identifying how organizations can assist in this process of stress and coping through the development of interventions and policies is therefore important to nursing practice. Organizations have the ability to not only eliminate environmental stressors as much as possible but can also provide a means to enhance the coping resources for hospice nurses.

Secondly, hospice nurses provide an essential function in the healthcare community: caring for and providing comfort to terminally ill patients. As life expectancy continues to rise, the need for hospice care will likewise increase. At present, hospice care has not escaped the existing nurse shortage. It is possible that workplace stress is a contributing factor to a decline in recruitment of and retention of nurses in hospice care. Not addressing this issue has the potential to severely threaten the viability of the hospice nurse specialty and ultimately hospice programs.

In an effort to avoid such an impact, this research highlights the need to address workplace stress for hospice nurses through a comprehensive and proactive approach.

Developing interventions that enhance the resources available for hospice nurses to cope with stressful situations increases the likelihood that stressors will be handled or coped with in a way that reduces both short-term and long-term adverse health consequence. Organizations reap the benefits of improved job satisfaction, retention and recruitment. A healthy workforce translates into quality care, which ultimately equates to positive health outcomes and the dignified and peaceful death that the hospice movement was founded upon. Improving the ways of coping for hospice nurses is a commitment and investment in caring for those who provide the best care.

APPENDIX A

INVITATION & RECRUITMENT FLYER

January 20, 2012

To Whom It May Concern:

I am a doctoral candidate at the University of Pittsburgh - Graduate School of Public Health working under the direction of Dr. Steven Albert. I would like to thank you for your interest in the Ways of Coping research project. This important research will examine workplace stress and coping strategies among hospice and palliative care nurses. Additionally, this research will explore how organizations can provide resources to assist in the coping process. Research will be conducted with nurses in the South Carolina coastal areas.

Participation in this study is voluntary. You must be a registered nurse (RN) or licensed practical nurse (LPN) working full-time for at least one year in a hospice/palliative care area. If eligible, you will be asked to participate in a focus group session and complete a brief questionnaire about your experience as a hospice nurse. Focus group sessions will be audiotaped and transcribed. The questionnaire is anonymous. Responses to the questionnaire will not be linked with the focus group session. Your name, contact information and any other personally identifiable information will be omitted from the results of this study. Final results will be published as a portion of my dissertation. A copy will be provided to your agency.

The focus group will take approximately an hour of your time. You will be contacted by phone or email with the date/time and location of the focus group. Refreshments will be provided. Every participant will be entered into a prize drawing for a Walmart giftcard.

I hope that you will consider participating in this worthwhile research. Your opinion will be a valuable contribution to hospice care! If you have any questions or need additional information, please feel free to contact me at [REDACTED]

If you are interested in participating you can:

1. Reply electronically by sending your contact information to [REDACTED]
 2. Reply by mail. Complete the form below and return to [REDACTED]
- OR
3. Reply by phone at [REDACTED]

Best Regards,

LaToya JM Harris, MPH, CPH
Primary Investigator

Name: _____ RN _____ LPN

Agency Name: _____

Telephone: _____ E-mail: _____

Best time to contact you: _____

COMFORT * HUMANE

COMPASSION * DIGNITY



VOLUNTEERS NEEDED

*for important research in
hospice care!*

This is a research study looking at work-related stress and coping in hospice care.

If you meet these 3 criteria...

1. A RN or LPN and
2. Full-Time and
3. Working in hospice care for the last year

YOU ARE ELIGIBLE!

This is a one time commitment and will only take approximately an hour of your time. You will participate in a focus group and complete a brief questionnaire. Refreshments will be provided. You will be entered into a drawing to WIN a Walmart giftcard!

Help improve the future of hospice care. **YOUR** opinion is needed!

CALL 843-849-3496 or email drljm79@gmail.com by Jan. 4, 2012

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APPENDIX B

SURVEY INSTRUMENT

INSTRUCTIONS

To respond to the statements in this questionnaire, you must have a specific stressful situation in mind. Take a few moments and think about the most stressful situation (work related) that you have experienced in the *past week*.

By "stressful" we mean a situation that was difficult or troubling for you, either because you felt distressed about what happened, or because you had to use considerable effort to deal with the situation. The situation may have involved an employee, supervisor, patient, patients family or something else important to you. Before responding to the statements, think about the details of this stressful situation, such as where it happened, who was involved, how you acted, and why it was important to you. While you may still be involved in the situation, or it could have already happened, it should be the most stressful situation that you experienced during the week.

Take a moment to briefly describe the situation below.

As you respond to each of the statements, please keep this stressful situation in mind.

Read each statement carefully and indicate, by circling 0, 1, 2 or 3 , to what extent you used it in the situation.

Key: **0** = Does not apply or not used **1** = Used somewhat
 2 = Used quite a bit **3** = Used a great deal

PLEASE RESPOND TO ALL QUESTIONS

Date: _____
(month/day/year)

Hospice Agency: _____

Marital Status (Check): __Married __Single __Divorced/Separated __Widowed

Gender (Check): __M __F

Age (Check): __ 18 – 24
 __ 25 – 34
 __ 35 – 44
 __ 45 – 54
 __ 55 – 64
 __ 65 >

Race/Ethnicity (Check): __ White
 __ Black or African American
 __ Asian
 __ American Indian/Alaska Native
 __ Native American/Pacific Islander
 __ Hispanic/Latino

Occupation (Check): __RN __LPN

of years as a Nurse: __ 1-2yrs __ 3 – 5yrs __ 6 – 9yrs __ 10+ years

of years as Hospice/Palliative Nurse: __ 1-2yrs __ 3 – 5yrs __ 6 – 9yrs __ 10+ yrs

of years employed at current agency: __ <1yr __ 1-2yrs __ 3 – 5yrs __ 6 – 9yrs __ 10+ yrs

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To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material;

Instrument: *Ways of Coping Questionnaire*

Authors: *Susan Folkman, Ph.D. and Richard S. Lazarus, Ph.D.*

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Five sample items from this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

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Sincerely,

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0 = Does not apply or not used 1 = Used somewhat 2 = Used quite a bit 3 = Used a great deal

1. I just concentrated on what I had to do next – the next step. 0 1 2 3
2. I tried to analyze the problem in order to understand it better..... 0 1 2 3
3. I turned to work or another activity to take my mind off things. 0 1 2 3
4. I felt that time would have made a difference –
the only thing was to wait. 0 1 2 3
5. I bargained or compromised to get something positive
from the situation. 0 1 2 3
6. I did something that I didn't think would work,
but at least I was doing something. 0 1 2 3
7. I tried to get the person responsible to change his or her mind. 0 1 2 3
8. I talked to someone to find out more about the situation. 0 1 2 3
9. I criticized or lectured myself. 0 1 2 3
10. I tried not to buy my feelings, but let things open somewhat. 0 1 2 3
11. I hoped for a miracle. 0 1 2 3
12. I went along with fate; sometimes I just have bad luck. 0 1 2 3
13. I went on as if nothing had happened. 0 1 2 3
14. I tried to keep my feelings to myself. 0 1 2 3
15. I looked for the silver lining, so to speak;
I tried to look on the bright side of things. 0 1 2 3
16. I slept more than usual. 0 1 2 3
17. I expressed anger to the person(s) who caused the problem. 0 1 2 3
18. I accepted sympathy and understanding from someone. 0 1 2 3
19. I told myself things that helped me feel better. 0 1 2 3
20. I was inspired to do something creative about the problem. 0 1 2 3
21. I tried to forget the whole thing. 0 1 2 3
22. I got professional help. 0 1 2 3

Go on to next page

APPENDIX C

INTERVIEW GUIDE

INTERVIEW GUIDE – Focus Groups

At the beginning of the focus group, the facilitator will introduce himself/herself and remind participants to keep the discussion confidential. The scribe will also be introduced.

Welcome/Overview

Good Morning/Afternoon. Thank you for taking the time to participate in today's focus group. Our goal here is to have an open dialogue about your experiences as a hospice nurse. Specifically, I want to better understand your perspective on work place stress and coping with that stress. The underlying assumption is that there are certain stressors involved in doing the type of work that you do. Hospice nurses, like you, have a better understanding of what it takes to continue to provide the best care to patients despite these stressors. I want to understand "how" you cope and what you feel your organization can do to help you continue to cope with work place stress. Your responses will be kept confidential.

Category: Introductory

What made you choose a career as hospice nurse?

What do you like most about your job as a hospice nurse?

Category: Ways of Coping

Tell me about some ways that you deal with stress on the job?

Thinking about your previous answer, describe which method you believe is most effective or useful in dealing with job stressors?

Category: Social Support

Think about a stressful event that occurred in the last two months, were you able to discuss the situation with any one?

How did you feel afterwards?

Category: Organizational Resources

What can you tell me about other programs or supportive things that your supervisor or job provides to help you deal with stressful events?

ADDITIONAL OPTIONAL QUESTIONS

What would you say you like least about your job as a hospice nurse?

When you hear the words "on the job stress" what is the first thing that comes to mind?

In your opinion, what do you consider the most stressful aspects of the job?

After a particularly stressful day what would you say is one of the most important things for you to do?

How do you unwind?

In what ways do your colleagues help when you encounter a stressful situation?

If you could, what programs or other things would put in place to help you and your colleagues manage work place stress?

APPENDIX D

IRB APPROVAL LETTER

From: irb@pitt.edu
Subject: PI Notification: IRB determination
Date: Thu, February 2, 2012 3:49 pm
To: ljm24@pitt.edu



University of Pittsburgh
Institutional Review Board

3500 Fifth Avenue
Pittsburgh, PA 15213
(412) 383-1480
(412) 383-1508 (fax)
<http://www.irb.pitt.edu>

Memorandum

To: LaToya Harris, MPH
From: Sue Beers, PhD, Vice Chair
Date: 2/2/2012
IRB#: [PRO11110006](#)
Subject: Ways of Coping - Understanding Workplace Stress and Coping Mechanisms for Hospice Nurses

The above-referenced project has been reviewed by the Institutional Review Board. Based on the information provided, this project meets all the necessary criteria for an exemption, and is hereby designated as "exempt" under section

45 CFR 46.101(b)(2).

Please note the following information:

If any modifications are made to this project, use the "**Send Comments to IRB Staff**" process from the project workspace to request a review to ensure it continues to meet the exempt category.

Upon completion of your project, be sure to finalize the project by submitting a "**Study Completed**" report from the project workspace.

Please be advised that your research study may be audited periodically by the University of Pittsburgh Research Conduct and Compliance Office.

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