Coping strategies used in residential hospice settings: Findings from a national study

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Abstract:
The purpose of this study was to explore professional caregivers' coping strategies for dealing with the deaths of patients in residential hospices in the United States. Using the Guide to the Nation's Hospices, 1996- 97, purely residential hospices were identified and invited to participate in the study. Employees at each residential hospice were asked to complete the Ways of Coping Questionnaire. Results indicated that positive reappraisal coping was the most frequently used coping strategy. Employees dissatisfied with the coping experience reported greater use of confrontive coping, escape-avoidance coping, and accepting responsibility strategies. The findings suggest that in-service training related to coping strategies and environmental interventions may help in strengthening the coping responses of residential hospice staff.

Article:

INTRODUCTION
Terminally ill persons who lack able caregivers can find solace in residential hospice programs. Such programs are now fairly common because more elderly are living alone, more adult children relocate away from their parents, and two-income households sometimes place an unbearable strain on the primary caregiver. In addition, persons living with AIDS often lack the social support that other patients may possess or have primary caregivers who are in the workforce.[1]

Staff members in residential hospice settings are exposed to relationships with patients that are unique from other hospice programs. Since the patient lives at the facility and the staff member works eight- to 12-hour shifts, greater interaction can occur for longer duration than in other hospice settings. Examples of the difference are found in the typical home care environment, where the staff member might make a visit that lasts for about an hour, or the acute care setting, where the average length of stay is 9.7 days, compared to 33.2 days in a residential setting.[2]

Patients in residential hospice programs are found at various stages of their terminal illness; some are walking, talking, and functioning with a high level of alertness not found in other hospice environments. With longer lengths of stay and more opportunity for active patient interaction, there is a greater opportunity for bonding between staff and patients to occur. When patients die, residential hospice staff members must cope with the death of a person with whom they have associated for eight hours a day for many days, weeks, months, or even years.

Within such a unique and intimate environment, it is important for hospice

Table 1. The eight subscales of the Ways of Coping Questionnaire	
Confrontive coping	Describes aggressive efforts to alter the situation and suggests some degree of hostility and risk-taking. Items = 6. Example: Showing one's anger to the individual who caused the stress. (Cronbach's alpha = .70)
Distancing	Describes cognitive efforts to detach oneself and to minimize the significance of the situation. Items = 6. Example: Acting like the stressor had not occurred. (Cronbach's alpha = .61)
Self-controlling	Describes efforts to regulate one's feelings and actions. Items = 7. Example: Trying not to share one's feelings with anyone. (Cronbach's alpha = .70)
Seeking social support	Describes efforts to seek informational support, tangible support, and emotional support. Items = 6. Example: Speaking with someone who could provide more information about a specific situation. (Cronbach's alpha = .76)
Accepting responsibility	Acknowledges one's own role in the problem with a concomitant theme of trying to put things right. Item's = 4. Example: Being critical of oneself. (Cronbach's alpha = .66)
Escape-avoidance	Describes wishful thinking and behavioral efforts to escape or avoid the problem. Items on this scale contrast with those on the Distancing scale, which suggest detachment. Items = 8. Example: Sleeping more than is normal for an individual. (Cronbach's alpha = .72)
Planful problem-solving	Describes deliberate problem-focused efforts to alter the situation, coupled with an analytic approach to solving the problem. Items = 6. Example: Figuring out possible solutions and putting great effort into making the solution work. (Cronbach's alpha = .68)
Positive reappraisal	Describes efforts to create positive meaning by focusing on personal growth. It also has a religious dimension. Items = 7. Example: Thinking about what is important in one's life. (Cronbach's alpha = .79)
Source: Folkman S, Lazarus R: *Ways of Coping Questionnaire Permissions Set Manual.* (Palo Alto, CA: MindSpring, 1988).	

administrators to understand how the staff copes with the deaths of the patients. By understanding the staff's coping strategies, administrators can provide support and interventions to further strengthen the coping responses of staff.

Folkman and Lazarus[3] suggested in their studies of coping strategies that people respond to stressful events in different ways, using different processes of coping. This study focused on assessing the coping strategies of professional caregivers in dealing with the death of a patient, and whether the caregivers deemed their coping experiences as satisfying. Perhaps by understanding some of the coping processes that residential hospice caregivers tend to use, support can be provided to assist the caregiver toward satisfying coping experiences and away from dissatisfying ones.

METHODS

Sample
Initially, 16 hospices were identified by the Guide to the Nation's Hospices, 1996-97[4] as purely residential sites. Each of these sites was contacted by telephone to verify that it was a purely residential hospice and employed staff on site at the residence versus contracting to a visiting staff program. Of these 16 sites, only 10 met the eligibility requirements. All employees of the 10 purely residential hospices made up the sample (n=199).

Measures
In a written questionnaire, subjects were asked to think about a patient death sometime in the past six months that was particularly stressful to them. Subjects were then asked to describe their satisfaction with how they handled the death, the strategies they used to cope, and characteristics of the patient who died. Demographic

characteristics of respondents and patients that might impact on coping processes and satisfaction were also measured.

A Likert scale was used by employees to rate their satisfaction with the way they handled the patient's death that they were asked to think about while completing the survey. Also, data were collected for the length of time the employee cared for the particular patient they were describing, and the patient's primary diagnosis, gender, age, race, and religious preference.

The 66-item Folkman and Lazarus Ways of Coping Questionnaire (WCQ) was used to assess coping strategies employed by staff when dealing with the death of the patient.[3] The WCQ measures coping processes, not individual coping styles. To measure coping styles would require analysis of several stressful encounters for one individual, followed by identification of consistencies across the encounters. The WCQ gives a descriptive picture of strategies used by the staff, and may be helpful in illustrating elements used in coping with loss in a residential hospice environment.

The WCQ is composed of eight scales,[5] described in Table 1. Each scale measures a method of coping used in a specific grief experience identified by the respondent. Past research with the WCQ indicates that individuals typically use a combination of strategies to cope, and some strategies are used more heavily than others.[3] Folkman and Lazarus[3] point out that estimates of internal consistency for coping measures are often at the low end of the acceptable range. However, Cronbach's alpha coefficients for the eight scales of the WCQ are higher than alphas reported for other questionnaires that attempt to measure coping processes (see Table 1). In addition to evidence of reliability, Folkman and Lazarus document construct validity for the WCQ: specifically, the WCQ study results are consistent with their theoretical predictions that coping consists of both problem-focused and emotion- focused strategies, and that coping is a process that varies by context of the stressful encounter.[3]

Subjects responded to each WCQ item on a four-point Likert scale, indicating how frequently each strategy was used. Anchors used in the WCQ are as follows: 0 indicated "did not use," 1 indicated "used somewhat," 2 indicated "used quite a bit," and 3 indicated "used a great deal." In scoring the responses, raw scores for each item were added to get the total scale score. An average item score for each scale was calculated and the anchors used to interpret how often the subject used the coping strategy.[3]

Employees' demographics, which the literature indicated might be related to coping processes and outcomes, were also measured. These measures included gender, age, marital status, months at present employment, education, job title, religious preference, race, and health status.

The instrument and data collection process were pilot tested at Beacon Place, a residential and inpatient hospice facility in Greensboro, NC. A site coordinator was identified, who distributed and collected the surveys and returned them to the principal investigator. The site coordinator and three subjects were then interviewed about the instrument and procedures. Minor changes in the wording of some questions occurred as a result of comments from subjects in the pilot study.

Procedures

Eligible residential hospices were telephoned to explain the study to the executive director or the director of the site, to obtain agreement to participate, and to ask the director to select a site coordinator for the project. Site coordinators were then contacted by telephone within a couple of days to explain the purpose of the survey, to ask how many questionnaires were needed, based on the number of employees working at the facility, and to give the time frame of the study. An incentive was also promised to site coordinators—by postmarking their facility's return packet by a certain date, they would receive a free beanbag toy.

Packets containing directions, questionnaires with envelopes, number-2 pencils, and a self-addressed, stamped, site-coded return envelope were mailed to site coordinators within one week. Upon receiving the packets, site

coordinators were instructed through the information letter to gather their group of employees, read the directions aloud, and distribute the questionnaires. The directions instructed subjects to think about the death of a patient sometime in the past six months that was stressful to them. By "stressful," it was explained that a situation surrounding the death was difficult or troubling for them, either because they felt distressed about what happened, or because they had to use considerable effort to deal with the situation. Upon completion of the questionnaires, subjects were instructed to enclose and seal them in the envelope provided and return them to the coordinator.

Reminders were given to site coordinators at one week and two and a half weeks following the mailing of the questionnaires.

Data analysis

Computer software tools (SPSS 7.5 for Windows[6]) were used to analyze the data. The data analysis included frequencies, summing scale total scores, computing scale and item mean scores, and t-tests for differences in item means.

Mean total scores were computed for the scales of the WCQ. To further examine the means found in each scale, the mean item score was calculated by using each subject's total on each scale and dividing by the number of items in each scale. This computation gave each subject an item average on the scale. All item averages were added together, then divided by the number of subjects, resulting in the mean item average. This analysis allowed for interpretation of the frequency of each coping strategy

Table 2. Characteristics of the respondents			
Factors		**Number**	**Percentage**
Age of caregiver	18 - 30	11	16.0
	31 - 40	15	21.7
	41 - 50	16	23.2
	51 - 60	23	33.3
	61 +	4	5.8
Age of patient	18 - 30	4	5.8
	31 - 40	8	11.6
	41 - 50	17	24.6
	51 - 60	9	13.0
	61 +	31	45.0
Months at present employment	1 - 12	15	21.7
	13 - 24	12	17.4
	25 - 36	15	21.7
	37 - 48	6	8.7
	49 +	19	27.5
	Not answered	2	2.9
Highest educational attainment	High school	5	7.2
	CNA training	20	29.0
	LPN degree	5	7.2
	Associate/Diploma	22	31.9
	Bachelor's	6	8.7
	Master's/Doctorate	10	14.5
	Not answered	1	1.5
Job title	CNA	27	39.1
	LPN	6	8.7
	RN	22	31.9
	Social worker/Counselor	4	5.7
	Administrator	5	7.3
	Other	5	7.3
Length of time caring for patient	Less than one week	3	4.3
	One to three weeks	10	14.5
	One to three months	30	43.5
	Four to six months	16	23.2
	Greater than six months	10	14.5

Table 3. Participants' reported satisfaction in handling a patient's death		
Satisfaction	**Frequency**	**Percentage**
Completely dissatisfied	3	4.3
Sightly dissatisfied	14	20.3
Slightly satisfied	19	27.5
Completely satisfied	33	47.8
Total	**69**	**100.0**

used by the employee. T-tests for independent groups were calculated by using item score averages for each coping scale to determine whether there were statistically significant differences between the coping strategy used and other variables.

RESULTS

Sample
Seven of the 10 sites responded. Two of the three sites that did not respond decided by the deadline that they did not want to participate in the study due to time constraints. The third site reported that the surveys were completed and returned in the postage paid envelope, but the investigator never received them. In all, 69 employee questionnaires were returned out of 126 employee questionnaires sent to the seven participating sites, for a response rate of 54.8 percent. A return rate of 35 percent should be noted when considering the 199 questionnaires sent to the 10 sites. The residential hospice facilities participating in this study ranged in size from six to 15 beds.

Some of the characteristics of the respondents are shown in Table 2. Of the 69 employee respondents, almost all were female. A majority of the respondents were white and over 40 years of age. Slightly more than half were married. Almost half had worked at their present employer for less than two years, while about one-quarter of respondents had worked there for more than four years. Most respondents had education beyond high school, but only about one-quarter of respondents had bachelor's or graduate degrees. Certified nursing assistants (CNAs) accounted for over one-third of the respondents, with registered nurses (RNs) accounting for approximately another third. Over half of the respondents described themselves as being Protestant, while almost a quarter of the respondents considered themselves to be of the Catholic faith.

Respondents were also asked their perceptions of specific demographic variables for the patient to whom they referred when describing a stressful coping experience. The reported ages of patients varied broadly, with the vast majority aged 51 or older. Patients were described as mainly female and white. When respondents were asked to describe their patient's religious preference, over half were reported as being Protestant. However, religious preference was reported as unknown for a significant number (17 percent) of patients. Respondents were also asked how long they had cared for the patient that they were describing. Over 80 percent reported caring for the patient for more than one month. The majority of patients had some form of cancer (68 percent). AIDS accounted for 19 percent and all other diagnoses accounted for 13 percent. An important factor to remember is that the descriptions of patients are not an example of the patient population in residential hospice facilities, but of patients that staff members used in their descriptions of a stressful experience in coping with a death.

Respondents varied on their perception of satisfaction with the way they handled the death that they were describing. Those satisfied with how they handled the death accounted for 75 percent of the sample, leaving 25 percent dissatisfied with their experience (see Table 3).

Analyses of the WCQ
While mean item averages found in Table 4 indicate that coping strategies of subjects fell somewhere between the anchors of "used somewhat" and "used quite a bit," most subjects did not use escape-avoidance, accepting responsibility, and confrontive coping.

T-tests were used to determine whether there were statistically significant differences between WCQ mean item scores for subjects reporting satisfaction with coping and those reporting dissatisfaction. In doing so, categories of satisfaction were combined to increase cell size. Completely dissatisfied and slightly dissatisfied became dissatisfied, and slightly satisfied and completely satisfied became satisfied. Table 5 suggests that subjects who were dissatisfied with their coping experience used confrontive, accepting responsibility, and escape- avoidance coping strategies more often than did subjects who were satisfied. No other statistically significant differences were noted.

Table 4. Mean item averages for Ways of Coping Questionnaire scales			
Coping scale	**Number of responses**	**Mean item average**	**Standard deviation (SD)**
Confrontive coping	61	.5984	.3948
Distancing	58	.7270	.5771
Self-controlling	61	1.1124	.6140
Seeking social support	60	1.0389	.6224
Accepting responsibility	57	.3640	.5002
Escape-avoidance	61	.3852	.4059
Planful problem-solving	62	1.2661	.6758
Positive reappraisal	60	1.3667	.7404
Note: N = 69; frequencies below a total of 69 indicate missing data.			

Analyses were also performed using chi-square tests and contingency table analyses to see whether coping scale scores differed by education, age groups, race, religion, or other factors. No significant differences were found.

DISCUSSION

Results from this study indicate that employees in residential hospice environments cope with a stressful patient death by using a variety of strategies, but tend to use positive reappraisal coping more than copers tested in other environments with other stressful encounters.[3] Perhaps, death being the stressor is a factor in the difference. Or, perhaps, persons with similar coping responses are drawn to work in hospices; therefore, they differ in their coping strategies as a whole from the rest of the general public.

While not every question of the 66-item WCQ will be discussed in this report, it is important to mention that about 85 percent of subjects used prayer in some way for coping. In fact, 47.8 percent of respondents indicated using prayer "a great deal." The use of prayer falls into the category of positive reappraisal in scoring, and supports the description of the scale as having a religious and faith dimension. These results indicate that many residential hospice employees may look at the stressful experience surrounding death as one of personal growth through their faith. Almost all of the respondents (97 percent) considered themselves as having a religious faith.

This finding is consistent with that from a study of the coping strategies of African American working women. Smyth and Williams[7] found the predominant coping strategy to be positive reappraisal and seeking social support. African American working women use social networks, such as family, friends, clergy, and church, for coping. The use of prayer was tied directly to the positive reappraisal scale in the subjects' coping processes.

In addition, the tendency to use positive reappraisal supports earlier findings of Folkman, Lazarus, Pimley, and Novacek.[8] These researchers, as well as others before them, found a consistent gender difference in coping—that is, women tend to use more positive reappraisal coping than men do. Since 93 percent of the respondents in this study were female, it is not surprising that positive reappraisal was used more often than other strategies. It may be common among hospices, in general, to have large numbers of female employees. Sontag,[9] in her study of hospice programs in one western state, found that 99 percent of hospice nurses were female and that 93 percent of hospice social workers were female. Therefore, one may suggest that hospice programs are predisposed to positive reappraisal copers, based on the gender difference.

Folkman et al,[8] also found that younger people tend to use more active types of coping than older people, who use more passive approaches, such as

Table 5. T-test for differences between mean item scores for subjects who were satisfied versus dissatisfied with their coping experience							
Scale	Satisfaction	N	Mean	SD	t	df	Significance (2-tailed)
Confrontive	Dissatisfied Satisfied	14 47	.8095 .5355	.3450 .3900	2.365	59	**.021**
Distancing	Dissatisfied Satisfied	13 45	.7564 .7185	.6583 .5594	.207	56	.837
Self-controlling	Dissatisfied Satisfied	15 46	1.2476 1.0683	.5752 .6258	.982	59	.330
Seeking social support	Dissatisfied Satisfied	13 47	1.0513 1.0355	.5585 .6445	.080	58	.936
Accepting responsibility	Dissatisfied Satisfied	13 44	.6154 .2898	.4284 .4998	2.126	55	**.038**
Escape-avoidance	Dissatisfied Satisfied	14 47	.5804 .3271	.4966 .3607	2.107	59	**.039**
Planful problem-solving	Dissatisfied Satisfied	15 47	1.2333 1.2766	.6690 .6848	-.214	60	.831
Positive reappraisal	Dissatisfied Satisfied	14 46	1.4388 1.3447	.5862 .7857	.413	58	.681

positive reappraisal. The sample used in Folkman's study is difficult to compare to the residential hospice environment because age groupings were much different, although note that almost two-thirds of this study's respondents reported their age as 41 years or older and are therefore considered to be middle-aged. The combination of the respondents being mostly female, religious, and mature seems to fit earlier findings in support of a dominant positive reappraisal coping approach.[8]

Those who were dissatisfied with their coping were more likely to use confrontive, accepting responsibility and escape-avoidance methods of coping, but even those dissatisfied did not use these strategies often, just more often than did those who reported satisfaction.

Folkman, Lazarus, Dunkel-Schetter, et al,[10] compared their subjects' coping processes over several different coping encounters and found that confrontive coping was associated with outcomes the subjects deemed as unsatisfactory, and that positive reappraisal was associated with satisfactory outcomes. The findings in this study support the former, but not the latter results.

Why confrontive coping would not be a satisfying strategy in the residential hospice environment is understandable because the scale centers on aggressive efforts to alter the situation. In hospice, the staff member actually has little power in altering the final course of illness, but does have some ability to alter the palliative nature of treatment. Confrontive coping also suggests some traits of hostility and aggression, which do not mesh well with an environment focused on palliative care, closure, and peace.

With the accepting responsibility method of coping, the person blames and criticizes herself for the problems at hand and is determined to make things right. Of course, in the hospice environment, this is ineffective toward a satisfying coping experience because the illness is in a progressive state and the patient is deemed terminally ill. Such a coping response can only lead to frustration and negative outcomes on the part of the caregiver.

With the escape-avoidance scale, the person uses wishful thinking in hopes that the situation or stressful event will go away. There is little wonder why such a strategy would have a dissatisfying outcome in the hospice residential environment— especially since the employee repeatedly must enter the same scene day after day on the job.

Implications
This study is important to hospice administrators in understanding the patterns of coping in the residential hospice environment. Such information is valuable in assessing a staff's tolerance to stressful encounters surrounding patients' deaths. Administrators, nurse managers, counselors, and health educators share the opportunity for further understanding of the residential hospice environment, and thus can show empathy in a sometimes stressful setting. Staff that express dissatisfaction in their coping experiences can perhaps be empowered with instruction on how to look at their stressful encounters as more of a growing and learning experience. Staff should be steered away from the three coping strategies that were found to result in dissatisfaction with coping outcomes. By identifying those types of coping strategies, administrators can encourage healthier, more satisfying means of coping.

That the religious theme is found in the frequently used positive reappraisal coping strategy should not be surprising. While hospices are ecumenical in nature toward patients and families, administrators should acknowledge the value of religion and its diversity as part of the coping processes of employees dealing with the deaths of patients. The need to acknowledge means that they need to provide outlets and support systems so that staff can freely express themselves in their own religious realm. Hospices are experts at doing this with patients and families, but may need some encouragement with their own employees to allow them to express themselves freely in their own diverse way.

While steering employees away from the coping strategies of escape-avoidance, confrontive coping, and accepting responsibility, perhaps staff should be taught an arsenal approach to coping. This study found that

people use varied types of coping across all coping strategies; therefore, assisting employees to find various helpful ways of coping may lead to satisfying outcomes. Employees can select their own coping strategies, based on their need, very similar to smokers trying to "kick the habit," where a variety of resources help in cessation, such as support groups, counseling, medication, and new activities in the place of the old behavior.

An assessment of the employee population and how it copes is a first step in understanding quality-of-life concerns and responses in the residential hospice setting.[11] Health educators and human resource professionals can use this information as a springboard to assessing the overall needs and aspirations of employees in such an environment. In addition, other environments that offer similar circumstances surrounding the deaths of patients, such as other hospice environments, long-term care facilities, and even hospitals, can benefit from the data collected in this study.

Limitations

Limitations of this study need to be acknowledged. While a 54.8 percent return rate is encouraging, the small sample size may have resulted in insufficient statistical power to detect meaningful differences. Additionally, nonresponse bias may have played a role in the results. Perhaps, those responding are different in some way from nonresponders, such as being more or less educated, more or less dissatisfied with their coping experiences, or more likely to have a specific job title.

By relying on subjects' recall in determining their coping responses to a stressful death, there may not have been an accurate depiction of how they actually responded. The subjects may have forgotten some of the circumstances surrounding the event and how they responded to the stressful encounters.

Also, site coordinators may have chosen employees to participate in the study on the basis of the convenience of their availability. Site coordinators working first shift may have surveyed only employees on first shift and not administered the questionnaire to those on less convenient shifts. In addition, site coordinators may have administered the survey to the subjects differently. An example might be that one site coordinator gathered the employees together and read the directions aloud, while another coordinator disseminated the questionnaires through interoffice mail.

Recommendations for future research

Future research should attempt to identify coping strategies that can be used to steer staff toward satisfying coping responses. This study identified which coping strategies should be avoided, but does not answer the question of specific strategies to promote.

Additionally, future research in this field should focus on goals of the professional caregiver. By understanding the specific goals of a coping employee, coupled with the actual responses of how the employee copes, the health educator can tailor programs to better meet the needs of residential hospice employees.

Also, research should focus on coping strategies of professional caregivers in other hospice environments, long-term care centers, and hospitals. Due to volunteer caregivers' growing popularity as a resource to care for the sick and dying, their responses to stressful deaths need to be studied as well.

Study of the job retention rate of employees on the basis of coping processes used in the work environment ultimately might provide a return on investment for the employer in identifying satisfying processes and providing intervention in steering employees toward more fulfilling coping responses.

CONCLUSION

This study reminds us that quality palliative care would be nearly impossible without the dedicated staff member. By providing coping resources and support, the staff member's job can be made easier and more

palatable. Our hope is that this study may help to create a dialogue between administrators and staff for better understanding of the issues surrounding how professional caregivers deal with the loss of their patients.

ACKNOWLEDGMENT

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