

# Coping in Caregivers

Stress and Coping Mechanisms of Hospice Workers

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# The Present Study

- Focuses on stress in hospice workers
- Goals:
  - 1) to further the current research on causes of stress and range of coping mechanisms in hospice workers
  - 2) examine the relationship between specific coping mechanisms and stress levels in the hospice environment
- The information learned from this study will be of use to hospice workers in aiding with coping and stress reduction needed in response to their job

# Hospice Care

- Designed to provide comfort and support to patients and their families when a life-limiting illness no longer responds to curative treatments
- Improves the quality of a patient's last days by offering comfort and dignity
- Hospice employees and volunteers must face the distressing topics of illness and loss on a regular basis
- The American Hospice Foundation stresses how important it is to use stress-reducing techniques



Stress is “a reaction to personal harms and threats of various kinds that emerge out of the person-environment relationship” (Lazarus, 1984, p. 771)

# The Stress Process

- The stress process:
  - 1) Causal agent
  - 2) Appraisal
    - Primary - “Is this event positive, negative, or neutral? If it’s negative, is it harmful or challenging?”
    - Secondary - “Can I do something about this? What can I do about this?”
  - 3) Coping Processes
  - 4) Reaction

# Coping Processes

- Coping is employing specific cognitive and behavioral strategies to manage situations appraised as harmful or challenging
- Ways of coping are organized according to their intended functions:
  - Resolving the stressful situation
  - Reducing event-related distress
  - Confronting or avoiding the source of the stress

# Ways of Coping

- *Active coping*
- *Planning*
- *Suppression of competing activities*
- *Restraint coping*
- *Seeking of social support for instrumental*
- *Seeking social support for emotional reasons*
- *Focusing on and venting of emotions*
- *Behavioral disengagement*
- *Mental disengagement*
- *Positive reappraisal*
- *Denial*
- *Acceptance*
- *Turning to religion*

# Why Coping Strategies are Important

- Stress is an important predictor of physical and mental health. Fontana and McLaughlin (1998)
- Coping strategies are not always effective in reducing stress. Pearlin & Schooler (1978)
- Failures in coping result in greater stress, which leads to ineffective coping. Menaghan (1983)



# Coping in Hospice Workers

- Stressors of hospice workers: lack of time to process emotions, volume of demands, paperwork
- Strategies of coping in hospice workers: social support, acceptance, physical exercise, spirituality (DiTullio & MacDonald, 1999)
- Hospice volunteers reported using: disengagement, turning to religion, positive reappraisal (Dein, 2011)

# Methods

## Participants

- Employees and volunteers of a hospice provider located in a suburban community in the Northeastern United States.
  - $N = 16$ 
    - 50% ( $N = 8$ ) hospice volunteers
    - 50% ( $N = 8$ ) hospice employees
  - Average time spent working in hospice care was about 24 months ( $M = 24.13$ ,  $SD = 18.42$ )

# Procedure

- Semi-structured interview
  - Used to assess what types of stressors the participant encounters at their job and in their daily life as well as how they cope with these stressors
    - In general, what do you feel is the most stressful aspect of your job?
    - Can you describe a recent workplace event that caused you stress?
    - Why is this particular event significant to you?
    - What support did you access regarding this event?
    - Demographics (highest level of education attained, years working in hospice, religious affiliation, etc.)

# Procedure

- The Ways of Coping Revised
  - Assess coping in reference to a specific event
    - 50 items (and 16 fill items)
    - 4-point Likert scale - 1 = 'not used' and 4 = 'used a great deal'
    - "Went along with fate; sometimes I just have bad luck."
- The Depression Anxiety Stress Scales (DASS-21)
  - Measures the severity of a range of symptoms common to both depression, anxiety and stress
    - 4-point Likert scale - 1 = 'did not apply to me at all over the last month' and 4 = 'applied to me very much or most of the time over the past month'
    - "I couldn't seem to experience any positive feeling at all."

# Main Hypothesis

Use of coping mechanisms will be related to reduced symptoms of depression, anxiety, and stress according to the DASS

(Dein, 2005; DiTullio & MacDonald, 1999; Sinclair, 2011, Timmermann, et al., 2009; Billings, 2002)

# Experimental Hypothesis

- Workers who have greater contact with patients will be more likely to employ active coping mechanisms, such as *social and emotional support* and *positive reappraisal*
- Workers who have less contact with patients will be more likely to employ avoidant coping mechanisms, such as *denial* and *disengagement*

# Results

- Scores on the WOC-R were computed based on the scoring method determined by Folkman (1985) and the current literature (Carver, et. al., 1989)
- Three separate scores were computed for the depression, anxiety, and stress subscales of the DASS
  - The sample's average scores were within the 'normal' range for each subscale (Henry & Crawford, 2003, 2005)
  - Variation in scores was consistent across each subscale

- Negative coping predicted higher anxiety scores,  $b = .92, p < .01$
- Negative coping predicted higher depression scores,  $b = 1.14, p < .01$ .
- Positive coping predicted lower depression scores,  $b = -.76, p < .01$



- Negative coping predicted higher stress scores,  
 $b = 1.03, p < .01$
- Positive coping predicted lower stress scores,  
 $b = -.51, p = .06$
- Religious coping approached significance as a predictor of higher anxiety scores,  
 $R^2 = .20, F(1,14) = 3.68, p < .07; b = .46$

- *taking responsibility* predicted higher anxiety scores,  $b = .73$ ,  $p < .01$
- *taking responsibility* predicted higher depression scores,  $b = .90$ ,  $p < .01$
- *social support for emotional reasons* predicted lower depression scores,  $b = -.54$ ,  $p = .01$
- *taking responsibility* predicted higher stress scores,  $b = .63$ ,  $p < .01$

# Correlations indicated significant ( $p < .05$ ) relationships between WOC-R responses and DASS subscale scores

- Depression
  - Taking responsibility,  $r = .63$
  - Disengagement,  $r = .58$
- Stress
  - Taking responsibility,  $r = .63$
  - Disengagement,  $r = .61$
  - Distancing,  $r = .58$
- Anxiety
  - Taking responsibility,  $r = .73$
  - Disengagement,  $r = .73$
  - Distancing,  $r = .55$
  - Restraint,  $r = .67$
  - Denial,  $r = .54$

## *Coping Mechanism Use According to Interview*

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Coping Mechanism	Frequency
Social support for emotional reasons	8
Distancing from stress	6
Confrontive coping	5
Planning	4
Positive Reappraisal	4
Turning to religion	3
Social support for instrumental reasons	3
Self-restraint coping	2
Denial	1
Disengagement of self	1

*Means and Standard Deviations of Coping Mechanism Use (WOC-R)*

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	Mean	Standard Deviation
Planning	2.82	.64
Social support for emotional reasons	2.47	.99
Positive Reappraisal	2.13	.81
Self-restraint coping	2.06	.55
Social support for instrumental reasons	2.06	.76
Distancing from stressor	1.92	.43
Turning to religion	1.84	1.03
Taking responsibility	1.73	.97
Confrontive coping	1.52	.36
Disengagement from stress	1.49	.62

# Coping mechanism use in WOC-R vs. interview

- Significant differences found for usage of religious coping,  $t(14) = -3.38, p = < .01$ 
  - WOC-R religious coping score for participants whose interviews indicated use:  $M = 3.0, SD = .71$
  - WOC-R religious coping score for participants whose interviews indicated no use:  $M = 1.46, SD = .81$


# WOC-R in employees vs. volunteers

- Employees practiced *denial* ( $M = 1.4, SD = .74$ ) more often than volunteers ( $M = 1.0, SD = .00$ ),  $p < .01$
- Employees *turned to religion* ( $M = 2.50, SD = 1.07$ ) more often than volunteers ( $M = 1.19, SD = .37$ ),  $p < .01$


# Influence of time spent working

- Employees had been working in hospice significantly longer ( $M = 35.25$  months,  $SD = 20.4$ ) than volunteers ( $M = 13.0$ ,  $SD = 5.35$ ),  $p = .01$
- Time spent working in hospice was not predictive of use of positive,  $R^2 = .15$ ,  $p = .15$ , or negative coping strategies,  $R^2 = .00$ ,  $p = .96$
- Time spent working in hospice was a significant predictor of *religious coping*,  $R^2 = .54$ ,  $p < .01$





“I deal with a lot of my stress...by God’s control, and especially if I sense that, you know, I’ve done the best that I can...Most of the time, I think in almost all cases I can do that...[another strategy] I would do if I needed is distraction.” - employee



“...awhile ago I didn’t go to church and then one of my patients, she passed away, she was younger, and she said about going to church, you know, that your life will start to get better. Then I started going to church and now I can’t wait for Sundays.”

“What do you feel when you go to church?”

“Like my stress is gone, everything, I’m just relieved of everything.” - employee

## *Situations Identified as Stressful during Interview*

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Type of Event	Frequency
Patient in pain/confused/acting 'off'	8
General uncertainty about course of action	3
Overworked/tight schedule	3
Problems with coworkers/non-patients	2

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Note: N = 16

# Discussion

- H1: Use of coping mechanisms will be related to reduced symptoms of depression, anxiety, and stress according to the DASS
  - Partially Supported
    - Positive coping predicted less depression and stress
    - Negative coping predicted greater depression, anxiety, and stress
    - Negative coping most influential on depression, anxiety, and stress


- H2: Workers who have greater contact with patients will be more likely to employ active coping while workers who have less contact with patients will be more likely to employ avoidant coping.
  - Not Supported
    - Employees practiced *denial* more often than volunteers
    - Employees *turned to religion* more often than volunteers

- *Taking responsibility* subscale of WOC-R may not measure a coping mechanism
  - Psychological control - the belief that one can determine one's own behavior and bring about desired outcomes (Taylor, 2012)
  - Items on scale may measure self-blame
    - Criticized or lectured myself.
    - I apologized or did something to make up.
    - Realized I brought the problem on myself.
    - I made a promise to myself that things would be different next time.

- Lack of consistency in coping mechanism use as reported during the interview vs. on the WOC-R
  - Except for *religious coping*, the strategies participants say they utilize to reduce stress are not what they actually turn to handle a stressful situation

“I have [coping strategies], I don’t know if I use them.”  
– employee

“Like, when I’m out working with the patients it’s more focused on the patients. Like, I don’t have time to focus on something different because I’m trying to help them and make them comfortable.” - employee

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- Death of client not reported as a stressful event
    - A study revealed that unexpected stressors are likely to be appraised as more threatening than expected stressors (Dugdale et al., 2002)



“Um, the most stressful thing is, probably, I’d say, not knowing what’s going to come all the time. Just because we’re not really told...what’s afflicting the residents there so we don’t know what could happen.” – volunteer

“There was, we went one day to visit Mrs. X and she was kind of out of it – I don’t know quite what she has but I think it’s Alzheimer’s... she thought we were her kids at one point and we were like, “Okay, we were not really trained for this situation.” So that was a little stressful.” – volunteer

# Limitations

- Lack of generalizability
  - Small sample size
  - Volunteers and employees from only 1 hospice facility
  - 81% female
- Confounding variables
  - Time spent working in hospice
  - Age
  - Gender
- Multiple analysts for the qualitative interviews

# Future Directions

- Inconsistencies in reported coping mechanisms
  - Possible result of methodology
  - Consider using situation specific and general coping measures
- Use of religious coping
  - Explore if used positively or negatively

# Applications

- Have more focused training for how to deal with unexpected events
  - “I think a lot of it for me is preparedness. Before I was really stressed out and didn’t know how to deal with it but, now that I’m more prepared, I’m better at dealing with the stress. And I think a lot of that translates into coping.” – volunteer
- Stress how to use positive coping mechanisms
  - “When something happens in hospice that is, like, sad or stressful, you also have to remember the better times... and know that it’s worth it in the end.” - volunteer

- Pay special attention to volunteer training

“As far as coping goes, I would be interested in learning about coping mechanisms myself because I haven’t had to really cope yet because she hasn’t passed. I don’t know what I’m gonna do, I really don’t – that’s a cause of stress.” – volunteer”

“I guess my main stressor for hospice is just because I’ve been with the same patient for so long that I really have become attached to her...I know that I’m going to have a really hard time when she passes away...I’m just hoping that it never happens. Ever. That I don’t outlive her.”

- volunteer



Questions?

# Selected References

- Carver, C., Scheier, M., Weintraub, J. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*, 56, 267-283.
- Dein, S. (2005). The stresses of volunteering in a hospice: A qualitative study. *Palliative Medicine*, 19, 58-64.
- DeLongis, A., Folkman, S., & Lazarus, R. (1988). The impact of daily stress on health and mood: Psychological and social resources as mediators. *Journal of Personality and Social Psychology*, 54, 486-495.
- DiTullio, M., & MacDonald, D. (1999). The struggle for the soul of hospice: Stress, coping, and change among hospice workers. *American Journal of Hospice & Palliative Care*, 16, 641-655.
- Fitzgerald, H. (2002). Managing stress for hospice professionals. Retrieved from: <http://www.americanhospice.org/articles-mainmenu-8/grief-at-work-mainmenu-11/54-managing-stress-for-hospice-professionals>
- Folkman, S., Lazarus, R., Dunkel-Schetter, C., DeLongis, A & Gruen, R. (1986). The dynamics of a stress encounters: Cognitive appraisal, coping and encounter outcomes. *Journal of Personality and Social Psychology*, 50, 992-1003.
- Greene, R. (2008). *Caregiver stress fact sheet*. Retrieved from: <http://www.womenshealth.gov/publications/our-publications/fact-sheet/caregiver-stress.cfm>
- Lazarus, R. (1993). From psychological stress to the emotions: A history of changing outlooks. *Annual Review of Psychology*, 44, 1-21.
- Sinclair, S. (2011). Impact of death and dying on the personal lives and practices of palliative and hospice care professionals. *CMAJ*, 183, 180-187.
- Timmermann, M., Naziri, D., & Etienne, A. (2009). Defense mechanisms and coping strategies among caregivers in palliative care units. *Journal of Palliative Care*, 25, 181-190.



# Thank You!!!!

Dr. Harring and Dr. Tjeltveit

Aimee Galicki

The For Our Sanity Senior Thesis Support Group

Dr. Sinno and Dr. Rudski

Dr. Wolfe and Dr. Sciutto