Mechanisms of Support: Coping with Loss in a Major Children's Hospital

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ABSTRACT. Employment in a children's hospital of a major medical center can be stressful for healthcare providers, especially when faced with potential losses of pediatric and adolescent patients. Although it seems natural to believe that emotional distress following the death of a patient would be addressed, this is not always the case. The current manuscript presents results of a survey of healthcare providers at Shands Children's Hospital at the University of Florida, a not-for-profit teaching hospital. Hospital staff (N = 94) responded to the survey with a 100% return rate. Responses identified situations considered to be stressful, and described how healthcare providers in this setting dealt with these incidents. Regarding existing hospital resources, respondents reported using multidisciplinary patient care conferences, social workers, and co-workers most often, as sources of support. Respondents also pro-

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vided a lengthy listing of recommendations for improvement. Addressing the issues presented in this study may result in improved employee retention and lower overall turnover rates.

KEYWORDS. Coping, pediatric loss, staff support, grief, burnout, needs assessment, stressors, staff turnover, psychosocial aspects of coping with loss

INTRODUCTION

Working in a major medical center can undoubtedly be stressful for healthcare providers, particularly in those areas of the hospital where healthcare professionals may be faced with numerous and frequent losses in the form of patient deaths. When the medical setting is a children's hospital, and more specifically, includes units such as pediatrics and neonatal intensive care, stressors can compound quickly, creating situations where burnout and staff turnover may become an administrative burden.

This manuscript is intended to address these issues by (1) reviewing existing literature on the topic, (2) introducing a process, developed by staff at a major pediatric facility, for exploring these issues, (3) presenting relevant findings from that exploration, and (4) discussing implications of the study for pediatric service providers concerned about safeguarding the emotional well-being of staff.

LITERATURE REVIEW

There is a wealth of literature in this area, particularly in the nursing journals. To highlight concerns that may be on the minds of administrators, a recently published article by Bosek (1999) featured a fascinating (and probably not unusual) case of a nurse and her response to a patient's somewhat unexpected death: she resigned from her position and sought employment in a "less stressful healthcare setting where it was unlikely that she would have to care for critical patients" (p. 12). One

major point of the Bosek article was that had resources been available, and had she accessed those resources for purposes of debriefing or dealing better with the stress related to the loss, there may have been a much less drastic ending to this episode.

Whether loss occurs during hospitalization or after the patient is discharged, the emotional distress which may follow the death of a patient (and this may be more true with a child's death) must be recognized and addressed. As a preventive measure to reduce the incidence of burnout in the healthcare professions, healthcare providers from all involved disciplines should be included in these efforts at early problem identification and resolution.

In a collaborative effort organized by a nurse and a social worker, Brown and Sefansky (1995) describe a multidisciplinary approach initiated in their facility to deal with the issue of how healthcare professionals cope with losing patients. A major focus of their approach is placed on how the loss affects family members as well as hospital staff. It is comforting to note that their bereavement committee members had the foresight to include a focus on those healthcare professionals who provide care for patients who do not survive. It is even more promising that they chose to do this using a team approach, with several disciplines represented. The committee is co-chaired by a nurse and a social worker, with regular monthly meetings. Another critical factor is their recognition of the need for staff education and training/in-services, which meshes nicely with the educational component provided for families. A 'bereavement packet' is given to the family; bibliotherapy is part of the overall effort, in the form of books provided to the family, to help them in dealing with and processing the loss. For those staff that cannot attend the in-services, videotaping of the sessions allows them to participate according to their schedule at a later date. One of the key conclusions: "the institution does not lose experienced staff because of burnout" (Brown & Sefansky, p. 64).

Spitzer and Burke (1993) describe a critical-incident stress-debriefing (CISD) program developed by social workers at Oregon's Health Sciences University. In one case, after several patients died within a short period of time, debriefings were scheduled to bring resolution to the following very real problems.

Staff members focused on their personal grief following the unexpected deaths, perceived loss of control, and gradual decrease in their ability to make necessary decisions. Some expressed resentment at colleagues who were calling in sick, whereas others were angry at a per-

ceived decrease in teamwork and communication. Some staff members experienced *increased startle response*, *nightmares*, *sleeplessness*, and *loss of objectivity* (Spitzer & Burke, 1993, p. 154, italics added for emphasis).

This brief listing of possible staff responses to a critical incident serves as a realistic warning of things to come, if no intervention occurs after this type of stressful situation. It is not unusual for staff to withdraw, to experience guilt and denial, to become physically ill and call in sick with a greater frequency than usual. Other symptoms that might lead to a clinical diagnosis of post-traumatic stress disorder often occur. According to Spitzer and Burke, nurses, social workers, secretaries and other ancillary staff most frequently attended the CISD sessions.

In an effort to learn more about how nurses are affected by patient deaths, as well as how they cope with loss of a patient in this manner, O'Hara, Harper, Chartrand, and Johnston (1996) administered the Impact of Patient Death Questionnaire (IPDQ) and the Multidimensional Scale of Perceived Social Support to 126 nurses at a continuing care and rehabilitation hospital in Canada. Based on their responses to two questions regarding how they were affected and to what extent, nurses were classified as either 'affected' or 'not affected' by patient death. Forty-two percent of the sample reported being negatively affected by patient death, with problems primarily related to morale, reduced efficiency in the workplace, and strained personal relationships. Using logistical regression analysis, one of the four variables which is a predictor of a nurse being negatively affected by patient death was a positive response to the following item on the IPDQ: "The younger the patient, the harder I find it to care for him/her" (p. 32). It is interesting to note that nurses in this study report that "sharing feelings and talking to others is helpful in dealing with the loss of patients" (pp. 33-34).

Other research findings indicate that seminars and in-service education on topics related to coping with grief and loss are certainly important components of an effective intervention. Nursing staff and others see these as increasing the probability of successful coping (Brown & Sefansky, 1995; Downey, Bengiamin, Heuer, & Juhl, 1995; Hinds et al., 1994; Kaunonen, Tarkka, Hautamaki, & Paunonen, 2000; Lewis & Robinson, 1991; Spitzer & Burke, 1993). It still seems odd that many healthcare professionals are not adequately trained in identifying and dealing with their own beliefs about dying patients. "Discussing death is common; however, few individuals can deal with direct experiences of death and other traumatic situations without bearing a heavy and often long-lasting psychological burden" (Saunders & Valente, 1994, p. 318).

THE UNIVERSITY OF FLORIDA STUDY

Setting

Shands Children's Hospital is a 'hospital within a hospital.' It is housed on three floors of Shands Hospital at the University of Florida, a not-for-profit teaching hospital. One floor houses six Intermediate Care beds and 64 General Pediatric beds. Another houses the 24 beds of the Pediatric Intensive Care Unit, while a third floor houses 19 beds in Labor and Delivery, 26 beds in the Mother/Baby unit, and 42 beds in two Neonatal Intensive Care Units. As part of a large tertiary care center, Shands Children's Hospital treats many of Florida's and the Southeastern United States' most critically ill children, from the most prematurely born infants to children who present with myriad diseases to those in need of state-of-the-art organ transplants. The medical units that participated were the Pediatric Floors, Pediatric Intensive Care Unit, Neonatal Intensive Care, and the Pediatric Oncology Unit. Pediatric allied health included clinical social workers, child life workers, rehabilitation therapists, chaplains, and pediatric medical residents. The actual staffing pattern is represented in Table 1.

Methodology

Because of growing concerns about stress, and an absence of a concerted, coordinated, and systematic approach to dealing with work-related stress in pediatrics, a staff support program instrument including a needs assessment component was developed. The instrument was designed by a social worker and a chaplain at Shands Children's Hospital at the University of Florida in Gainesville, to determine the type of problems that exist particularly for nurses and other healthcare providers who care for hospitalized children on a daily basis. Development of the instrument was the direct result of a request from the director of nursing service, as a first step in later preparation of a systematic response program to help nursing staff and other healthcare professionals in dealing with pediatric bereavement and loss of patients, regardless of whether the loss is expected. There was already an informal system of response to staff needs. Both individually and as a group, staff had expressed concerns regarding their level of stress, as well as their need to

TABLE 1. Demographics of Sample Respondents (N=80)

		Frequency	Percent
Discipline	Nursing	67	70.5%
	Occupational Therapist	1	1.4%
	Pediatric Resident	9	9.5%
	Physical Therapist	6	6.5%
	Respiratory Therapist	1	1.4%
	Social Worker	7	7.5%
	Clerk	3	3.3%
	Total	94	100%
Years of Experience in Peds (N = 92)	5 Years or less	31	34.0%
	6 - 10 Years	26	27.5%
	11 - 15 Years	19	21.5%
	16 - 20 Years	11	11.5%
	21 Years or more	5	5.5%
Work Units (N = 91)	Pediatrics Primarily	54	59.5%
	Multiple Units	37	40.5

grieve and directly deal with specific issues and cases. In other words, it was recognized that the informal process needed to become more formalized. The social worker and chaplain chosen for this project were selected based on their personal interests and experience in working directly with patients and staff on the units in question; they both worked in Pediatrics, and both had a previously identified interest in this area of study, as well as a long history of successful interdisciplinary collaboration (nurses, social worker, and chaplain). No sampling procedures were used, as all professional caregivers working on pediatric units within this hospital participated in the current study. This included nurses, social workers, physical therapists, occupational therapists, clerical staff, case managers, chaplains, patient representatives, medical students (residents), and others as available.

Instrument

The instrument was three pages in length, utilizing a variety of questions and open-ended response items. The social worker and chaplain developed questions and items for the instrument based on their long work experience on these units and professional readings in this area. The instrument was not pretested, but there was a general consensus among those involved that the information to be collected using this tool

would be useful in further addressing the issues related to work-related stress. After indicating their discipline, number of years of pediatric experience, and unit to which they belong, staff completing the survey were asked to identify specifically the situations or incidents which they found most stressful in dealing with hospitalized children. Respondents were asked to describe incidents which may be distressing to them as part of a group, or individually. Next, participants were asked to rate how well they felt they were coping with these and other situations, on a 4-point scale; the responses included very well, good, fair, or poorly.

Nine categories of available in-house resources were listed and staff were asked to indicate their familiarity with these resources by choosing one of the following choices: 'Would not use,' 'unaware of how to access,' 'desire more information,' 'aware of resource,' or 'use resource.' Respondents were also asked about personal resources used outside the medical center, such as family members, therapists, friends, clergy, or significant others. In an effort to begin assessing which resources were more likely to be used with some regularity, staff members were asked whether they would use certain resources if they were made available. Those resources include group work, rituals for remembering/celebrating, rituals for closure, education and skill building, or a journal club.

Lastly, participants were encouraged to provide additional input regarding their own suggestions for developing a comprehensive, coordinated response program for providing staff support. This section of the survey was expected to yield the most comprehensive qualitative data, in the form of actual staff comments and recommendations.

The instrument was distributed by the nurse case managers, department supervisors, and chief resident at regularly scheduled team and department meetings. Each of these individuals sent one reminder for completion and return of the forms. (Copies of the instrument are available from the senior author.)

Results

Ninety-four members of the hospital staff responded to the questionnaire, for a 100 percent return rate. Table 1 presents a description of the sample in terms of professional discipline, years of experience in pediatrics, and primary work unit. The sample consisted primarily of nurses (n = 67), and had a mean of 9.1 years of experience in pediatrics (SD = 6.68). Nearly 60% of the respondents (n = 54) worked only in pediatrics, while over 40% (n = 37) were responsive to more than one unit, in-

cluding neonatal ICU, BICU, labor and delivery, education, BMTU, mother and baby, and pediatric ICU.

Data analyses revealed that sixty-two percent of the respondents (n = 59) reported that they felt their stress and coping ability was "good," and 26 percent (n = 25) rated themselves as coping "very well" with stressors of hospitalized children and their families. Ten percent felt that their coping skills were only "fair" (7%) or "poor" (3%). Respondents endorsed the use of most personal mechanisms of support to a high degree. Seventy-three percent (n = 70) said they used family members, sixty-six percent (n = 63) endorsed the use of clergy, seventy percent (n = 67) endorsed the use of a friend, forty-nine percent (n = 47) endorsed the use of a spouse, and thirty percent (n = 29) endorsed the use of a therapist.

'In-House' Resource Use

Table 2 provides the percentages of responses for each of the in-house resources. Hospital resources used included staff chaplains, clinical social workers, ethics committee, bioethics coordinator, CISM (Critical Incident Stress Management) response team, multidisciplinary conferences, hospital co-workers, and nurse management. Hospital coworkers, 78% (n = 73) and clinical social workers, 70% (n = 66) were the most heavily utilized resources within the hospital setting. More than one-half the respondents (61%, n = 57) used nurse management as a resource, and 46% (n = 43) used multidisciplinary patient conferences. At the other end of the utilization continuum, only one person used the crisis response team (CISM) as a means of support. Awareness and knowledge of a resource appeared to be an indicator of resource use. Forty-three percent reported not knowing how to access the crisis response team, forty-four percent lacked access information for the bioethics coordinator and 19% reported not knowing how to access the ethics committee. Conversely, only 9% of respondents reported not knowing how to access the multidisciplinary patient conference, 5% were unaware of how to access the chaplains, 3.8% did not know how to access social workers, 2.5% nurse management and only 1.3% reported being uninformed about how to utilize hospital coworkers.

Another interesting indicator of utilization of hospital resources is obtained by combining the number of those respondents who endorsed awareness of a resource with the number of those respondents who indicated use of that resource, then computing the percentage of that group who actually used the resource. This generates an estimation of the rate

TABLE 2. Percentages of Respondents Using Existing Resources

EXISTING RESOURCE	USE RESOURCE NOW	AWARE OF RESOURCE	UNAWARE OF HOW TO ACCESS	DESIRE ADDITIONAL INFORMATION
Hospital Chaplains	32.5	56.3	5.0	1.3
Social Workers	70.0	23.8	3.8	1.3
Ethics Comm.	15.0	55.0	19.0	10.0
Bioethics Coord.	5.0	11.3	44.0	33.0
CISM (Response Team)	1.3	13.8	43.0	34.0
Multidisciplinary Patient Conference	46.0	37.5	9.0	6.3
Hospital Co-Workers	78.0	20.0	1.3	0
Nurse Mgmt.	61.0	31.3	2.5	0

of 'knowledgeable utilization' of a particular resource. For example, although 89% (n = 84) of all respondents were aware of chaplain resources, only 31 respondents used them. In other words, only 38% of those who were aware of chaplain services used them. This is contrasted by 72% of all those who were aware of social work resources using them and 62% of all those who were aware of nurse manager resources using them.

With regard to needed resources, respondents were presented with a list of potential resources and asked if they would use them: Thirty-three percent (n = 31) said that they would use both rituals of celebration and rituals of closure if available, 33% (n = 31) said they would use a journal club and 29% (n = 27) said they would participate in a support group if offered. Forty-six percent (n = 43) said they would participate in education and skill building if available.

A number of tests were conducted in order to determine if any of the variables reported on the survey appeared to mediate the perceived coping ability of the respondents. A step wise regression analysis was conducted with the hospital-related coping mechanisms and years of pediatric experience serving as the independent variables. The measure of coping was regressed on the nine mechanisms and years of experience. None were found to be related to better coping. A second regression anal-

ysis was conducted using coping mechanisms outside of the hospital as the independent variables. These included using a family member, therapist, spouse or significant other, a close friend and a clergy. A stepwise regression, with respondents' assessment of perceived coping as the dependent variable, proved significant, $f = 10.15$, $p = .0020$, with talking with a family member (other than spouse) as the only significant predictor of better coping accounting for over 10% of the variance, $r^2 = .107$.

A series of t-tests was conducted in order to determine if working on a particular unit might lead to increased stress. Results indicated that stress was not related to working on any specific unit. However, when respondents who worked exclusively on one unit were compared with those worked on more than one unit, those who worked solely on one unit endorsed significantly greater difficulty in coping ($m = 3.4$) than those who rotated units ($m = 2.9$), $t(df = 89) = 3.70$, $p = .000$.

Qualitative Responses

Additionally respondents were asked to describe the most stressful incidents to the work group and to them as individuals. They were also asked to make recommendations for mechanisms that might attenuate stress. Table 3 includes a listing of three types of qualitative responses. Regarding situations (in the care of hospitalized children and infants) that were stressful to staff as part of a group or team, there were 14 different responses. Six of those were mentioned more than once, and three were mentioned more than five times (parents who were angry at staff, death of an infant, and indications of child abuse). Responses describing individual stressors repeated this theme. Of the seventeen responses in this section, seven were mentioned more than once, and four were mentioned five or more times (angry parents, death of a child, workload concerns and child abuse).

The third column in Table 3 includes recommendations thought to be helpful in terms of addressing the issues identified in the first two columns. The 23 suggestions provided by respondents for reducing stress included more regular support group meetings, greater consistency in scheduling of debriefings in child death situations, greater availability of chaplains and social workers (especially those who could be available in the evenings and at night), development of a 'quick response team,' monthly staff lunches, and more training in the form of workshops and in-services. It seems quite revealing and most likely an important finding, that respondents specifically requested more social workers and more chaplains. Having more social workers and chaplains

TABLE 3. Group and Individual Stressors mentioned by participants, followed by Recommendations for Improvements

Group Stressors	**Individual Stressors**	**Recommendations**
Goals not clear	*Angry parents**	Regular MDT meetings
Family grief	*Death of child**	Patient conferences
*Angry parents**	Caregiver non-compliance	Rituals
Last minute referrals	Poor discharge planning	More clinical social workers
Lack of communication	*Unrealistic expectations*	More team building
Divisive family members	*Too heavy workload**	More inservices/training
Futile care	*No debrief after death*	Monthly staff lunches
*Death of infant**	Sudden death	*Quarterly 'fling'*
Discussing diagnosis	*Child abuse**	Quick response team
Discussing prognosis	Difficult family members	Team meetings (support)
Poor discharge plans	Multiple deaths	More availability
Low parental involvement	*Limited resources for family*	Education/Skills building
*Child abuse**	End of life issues	More guidelines
No debriefing after death	Critical admissions	Workshop on resources
	Poor staff communication	Support for new staff
	Unexpected death	More staff
	Suicide	Less administrative pressure
		Monthly support group
		More chaplains (after hours)
		More night support
		Incident checklist
		Incident debriefing
		More debriefing in general

Items in italics were mentioned more frequently.
Items with an asterisk were mentioned at least 5 times.

would increase their overall accessibility for staff who find them highly supportive, especially during stressful events. Social workers and chaplains primarily concern themselves with addressing the needs of patients and families; additional staff in these two areas would allow more specific efforts to be directed towards assisting faculty and staff learn more effective ways of coping with stress and loss. An internal response team could be formed, which would be more readily available and better able to meet the needs of the hospital environment. Regarding training, respondents asked for education in stress management, time management, loss and bereavement, as well as support groups for staff and faculty.

DISCUSSION

A significant finding was the result that the great majority of respondents (88%) appraised their ability to manage stress as good or very

good. This would support the notion that success in continued employment in areas of pediatric trauma is partially predicted by workers' self-appraisal of coping competence in dealing with stress. The high degree of reported use of co-workers as sources of support underscores the importance of teamwork and worker-generated collateral bonding on pediatric units. It is speculated that the high degree of co-worker reliance underscores the need for support from those who "are going through it too." It is also possible that the need for support in managing stress is rather unpredictable, temporal and immediate, thereby increasing the need for support in the 'here and now' rather than meeting with someone afterward. Certainly these conjectures merit exploration.

Similarly, the extensive use of social work staff by other disciplines underscores the importance of cross-disciplinary support and affiliation in stressful working environments. Furthermore, it appears that the reported use of hospital resources is related to respondents' awareness of the resources, as further indicated by the finding that the crisis response team was used as a means of support by only one person. This suggests that efforts need to be made to publicize those support resources that are less visible to staff. In fact, patterns of 'knowledgeable utilization,' that percentage of known resources that are actually used, suggest that respondents are selective and discriminating when utilizing support resources. Clearly, another factor that must be considered is the overall staffing pattern. Closer examination reveals that while there are 13 social workers (with offices on the individual units), there is only one chaplain to cover the entire children's hospital. If 32.5% of respondents report using chaplains as a source of support, this fact alone makes for an interesting observations regarding utilization of resources (personnel).

Despite the fact that some mechanisms were clearly used while others were not, it does not appear that utilization of particular mechanisms of support within the hospital leads to appraisals of better stress management. This finding supports the literature that successful methods of managing stress must be personalized rather than proscribed. Conversely, among the non-hospital support mechanisms, use of a family member other than a spouse was the only significant predictor of better stress management for the respondents. This seems to support the literature on general stress management, which suggests that supportive contact within the family environment is a good indicator of successful stress management. However, the authors found it a bit surprising that respondents in this study used other family members more than spouses in stress management. We conjecture that there could be several reasons for this: (1) other family members may have been more available than

spouses; (2) spousal support may be perceived by respondents as more tacit, or understood without being openly expressed; (3) there may be a reluctance on the part of respondents to discuss stressful work events within the marital dyad; (4) other family members may be perceived as being more able to provide support; and/or (5) the finding itself may be an anomaly and have no significance. In any case, this may warrant further exploration in future studies. Of greater importance is the conclusion that having others to talk with, as one experiences stressful events at work, is an essential element in successful stress management.

Perhaps most significant is the finding that working on more than one unit led to appraisals of better stress management. It is obvious that movement between more than one unit leads to contact with a greater number of people and perhaps enlarges the support network. It is also likely that a change from one unit to another may create 'artificial breaks' in stressful events. More importantly higher appraisals of coping were not related to differential levels of stress on particular units. This lends strength to the notion that variation of the physical work environment and related tasks may be a component of better stress management.

Suggested Modifications Within the Hospital

Of the suggested modifications included in the questionnaire, all, with the exception of more opportunities for education and skill building (endorsed by 45%), were endorsed by about a third of the respondents. This again suggests that there is no best mechanism, in the mind of the respondents, for stress management. Rather, the key appears to be the availability of a diverse array of support mechanisms. This point is supported by the qualitative responses as well.

Many of the suggestions made by respondents incorporate approaches similar to recommendations from recent literature describing programs for staff and families experiencing loss (Chapple, 1999; Fost, 1999; Hammer, Nichols, & Armstrong, 1992; Herrle & Robinson, 1987; Hittle, 1995; Johnson et al., 1993; Rothman, 1997; Sutcliffe, Tufnell, & Cornish, 1998). We conclude that it is essential in successful stress management for employers to actively respond to the needs and suggestions of employees and to make provisions within the work environment. This might take the form of ongoing program development in stress management. This would also entail regular periodic (scheduled) program evaluation of the stress management component, such as the

one conducted above, and include evaluation of the effectiveness of any modifications in the stress management program.

Implications for Healthcare Professionals

The importance of available and pragmatic methods of stress management in dealing specifically with issues of grief and loss on the part of staff is underscored in this study. However, the management of grief, loss, personal distress and compassion fatigue on the part of healthcare professionals appears to be largely an informal process, with some formal support and provisions. It appears that many health care professionals have been successful in developing an informal model of stress management and have spent significant amounts of on-the-job time doing so. However, the authors believe that the next step in increasing the effectiveness of stress management in 'loss' settings is to centralize these informal processes in one's job performance. Thus we suggest explicitly building expectations and provisions for grief and stress management into formal position descriptions. In other words, the personal management of one's grief and stress is made into a formal duty. This does not abrogate the employer's responsibility in attending to the stress of employees. Although health care professionals must be attentive to their own processes of coping and stress management (Figley, 2002; Ospina-Kammerer & Dixon, 2001), it is incumbent on employers to provide an environment in which this can be accomplished. Many helping professionals may not recognize critical stress levels or perhaps be in denial when experiencing high stress levels. Thus there is the need for employers to provide regular education regarding the symptoms of stress, to be sensitive to the manifestations of symptoms in employees and to respond to such changes. Although many healthcare professionals are aware, hypothetically, of the importance of stress management, in practice some may lack the awareness, skill, or opportunities to accomplish this task. Discrete attention to stress management, in the form of classes or courses, appears to be lacking in many professional degree programs. Moreover, explicit formal attention must be paid, by both employees and employers, to the importance of continually addressing the processes of grief and stress management for healthcare providers in this setting.

CONCLUSION

As suggested in the study, effective methods of stress management vary from person to person. Thus it is important that formal support provisions have an array of highly visible and readily available options for staff. Although some resources may be utilized more than others, it is not apparent that utilization patterns reflect the effectiveness of particular resources. Rather, our results suggest that it may be a combination of both personal preference on the part of workers and visibility of the resource which influence utilization. We believe this focus on visibility and availability of support persons requires that resources be visible and available continually rather than 'in times of need' so that they are seen as a formal part of the unit.

The frequent use of co-workers in stress management suggests that it is an active process on the part of workers that is, in part, a function of ongoing relation-building, including trust-building and team-building. This also suggests that formal processes of stress management should be built from the inside out with the active participation of line workers including, as the final authority on what processes should be included. The importance of this contention is supported by the large number of suggestions generated by participants in the current study.

Starting with orientation, the importance of consistent attention focused on issues of stress management in dealing with grief and loss must be made explicit. Orientation should not only include information regarding the available resources but a modeling component of successful stress management provided by accounts of successful strategies given by workers. As with other formal job expectations that are highlighted in orientation, appraisal of ongoing stress management may be included in annual evaluations of job performance. From an administrative perspective, efforts in this area may result in improved employee retention and lower overall turnover rates. According to our results successful coping was associated with working on more than one unit. Based on current study findings, offering employees the option of unit rotation may prove valuable in reducing work-related stress. The authors recognize that while this seems a reasonable supposition, further study may be necessary to demonstrate the validity and feasibility of this recommendation, since rotating among different units may produce other unintended stressors, due to different requirements for procedures, exposure to leadership styles that may constrast considerably with management styles on the employees home unit, changing demands for care, and new work conditions and schedules. Clearly, management would need to emphasize that

these changes were initiated specifically in an ongoing attempt to improve mental health of hospital employees.

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