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THE "DOUBLE NIGHTMARE" OF PHYSICAL ILLNESS IN THE CHRONICALLY MENTALLY ILL: A QUALITATIVE RESEARCH STUDY OF THE IMPACT ON SOCIAL WORK PRACTICE

by

Phyllis Mervis-Itzkowitz

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, the City University of New York.

2002

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Abstract

THE "DOUBLE NIGHTMARE" OF PHYSICAL ILLNESS IN THE CHRONICALLY MENTALLY ILL: A QUALITATIVE RESEARCH STUDY OF THE IMPACT ON SOCIAL WORK PRACTICE

by
Phyllis Mervis-Itzkowitz

Advisor: Dr. Irwin Epstein

This dissertation is a qualitative research study of social workers' experiences in community-based settings where chronically mentally ill clients now have co-occurring physical illnesses and/or are dying. The study focused on the occupational and personal stresses this work has created, and on understanding how these professionals coped and transcended these stressors.

The study was conducted more than two decades after the public welfare policy of deinstitutionalization was at its height. The problem addressed in this study is in part an unplanned outgrowth of that policy. Neither lawmakers or community programs, which have 24 hour responsibility for the care of these individuals, anticipated that a significant proportion of these mentally ill adults, as well as others who were never hospitalized and may have been homeless, would eventually develop physical illnesses associated with aging or HIV and AIDS.

The study found that physical illness represents a serious occupational stress for mental health professionals, many of whom consciously chose to avoid work in medical settings. The participants described feeling personally and professionally vulnerable.

One aspect of the stress identified is consistent with health care literature that discusses the emotional impact of serious physical illnesses on staff in the "secondary practice setting" of the hospital. However, there are additional, intensified stresses for mental health professionals in the primary mental health care setting who have 24 hour responsibility for their clients, have been educated to work with the chronically mentally ill, and have expressed a preference for this practice setting.

The study also found that social workers faced with these stressors demonstrated resilience and resourcefulness and described personal and professional gratifications that offset the personal and professional demands of their work.

The exploratory nature of this study, limited sample, and single study site render these findings tentative. Nonetheless, they suggest a role for social work education and agency administrators in preparing and supporting staff in an environment where physical illness has become a regular aspect of their mentally ill clients' profile. There is also a role for research to examine the place of professional values in buffering worksite stress and in determining how generalizable these findings are.

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This dissertation was a project that took many years to complete. It was interrupted by assorted trials. There were many people who supported, assisted, encouraged, taught, and inspired me. Their help made this dissertation a reality.

I would like to thank the staff who participated in this study. They freely gave of themselves and their time in the hope that this research would contribute to a clearer understanding of their experiences. I hope this study lives up to their expectations. They have certainly lived up to my expectations of what dedicated, committed mental health professionals should be.

I am especially grateful to the members of my committee. Each of them has had a specific influence on my development as a professional as well as a specific role in the creation of this work. Each of them also represents an aspect of what I aspire to. Mildred Mailick was a steady beacon. Her knowledge, insights, teaching abilities, and practice skills are a model for me of the best of combined academic and clinical work. Robert Salmon was a source of quiet objectivity and congenial encouragement. I also was strengthened by his support and nurturing of my interests in social work group treatment.

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This dissertation is dedicated to my father, Earl Mervis.

He would have been proud.

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It's a double nightmare for me. As a person I feel vulnerable, as a clinician sometimes I feel helpless, and sometimes I feel like I am here to hold the reality and educate and help them manage.

. . . a social worker

Chapter I

Introduction and Formulation of the Problem

Introduction

This dissertation represents an exploratory effort to understand the experience of mental health professionals in community based, psychosocial programs where the persistently mentally ill clients either have co-occurring continuing physical illnesses or are dying from them. In addition to defining the nature of this occupational challenge, the study sought to document how the staff negotiate these complex demands and what contributes to effective coping.

The study is in keeping with the doctoral program's expectation that the dissertation identify an unmet need or problem within the domain of social welfare. There is already a body of social work literature that describes stresses and coping methods associated with social work practice in high stress *medical* settings and with AIDS patients. The literature also recommends the development of supportive interventions with these staffs. At present, however, there are no references to this practice concern for social workers in mental health settings whose patients have become physically ill.

The study's focus also resonates with concerns expressed in articles about "the implementation of practice models (in occupational social work) that ignore...stressful work environments as determinants of individual problems of workers..." (Donovan

1987, p. 259). In support of this claim Donovan goes on to cite Abramovitz and Epstein's (1983) contention that in social work "the emphasis on individual and family problems deflects attention from problems in the workplace and is a 'subtle version of blaming the victim.' "

The impetus for this study grew out of consultations in 1994 which this investigator conducted with staff at a state-run psychiatric outpatient facility and at a not-for-profit, community based, mental health agency providing social services and housing to chronically mentally ill clients. In both settings social work staff were concerned about the large number of mentally ill clients in their care who were aging and becoming physically ill with serious and/or life threatening illnesses or dying. Additionally, many of their younger clients were either infected with HIV or had AIDS and were also dying.

Many of these staff members had had positive experiences in group meetings where they felt they could discuss concerns and from which they drew support. These experiences had led them and their administrators to request the group consultations.

These initial consultations revealed that the impact of clients' physical illnesses and deaths included:

1. Feelings of pervasive frustration at seeking to provide services to a needy population where resources are increasingly limited.

2. A compromised sense of professional competence as clients were unable or unwilling to comply with treatment regimens. Accordingly, staff described feelings of failure even though they acknowledged the difficulties and realities of the situation.
3. Post death case management issues: Following a client's death the professional staff described having to respond to the reactions and needs of other anxious, grieving clients who participated in group activities.
4. The appearance of angry feelings toward clients and other staff members which feelings were then turned against the self, a more "professionally acceptable" response, as well as projected against the larger, "uncaring" system. All of this appeared to contribute to feelings of low morale.
5. The increased use of personal sick time and the appearance of new physical problems such as substantial weight gain.
6. Debilitating preoccupation with thoughts of personal physical well-being, a concern exacerbated a colleague's recent death from AIDS.

In short, confrontation with clients' serious physical illnesses and/or deaths seemed to stir up personal and professional conflicts and stimulate powerful feelings, feelings already noted by Fortune, (1987, 1992) in discussions about the reactions of medical staff. For staff who are professionally trained and prepared to work with mental illness but not with medical illness and/or death, the emergence of these feelings may interfere with their ability to work effectively and satisfactorily.

Formulation of the Problem

Working with the persistently mentally ill has always been stressful. The literature that examines the nature of this worksite stress targets several sources. It is noteworthy, however, that physical illness has not been cited in the literature as one of the specific strains. Principal among the recognized stressors are the psychosocial characteristics of various client populations and the organizational/environmental factors inherent in social service settings.

More specifically, the very chronicity of seriously mentally ill clients' psychiatric problems and the subsequent slowness of their progress or improvement are frequently cited as significant strains for mental health staff. In a study intended to define the social and psychological dimensions of burnout in mental health staff, Pines and Maslach (1978) found that "the higher the percentage of schizophrenics in the patient population, the less job satisfaction staff members expressed" (p. 234). Minkoff and Stern (1979, 1982) describe a "stress-producing dilemma-a paradox-when their skills do not 'work' with chronic patients" (p. 859). Farber and Heifetz (1982) note that professionals feel inadequate or "therapeutically unsuccessful" when working with a population where they cannot evaluate accomplishment. White and Bennett (1981) concur. They point out that this "attitudinal barrier" to working successfully with chronically mentally ill individuals is related to the professional's unrealistic expectations and the fantasy "usually consciously denied" that he/she will be able to cure the patient. "They expect the patient to respond quickly to treatment, and may be frustrated or disappointed when their best efforts fail" (p. 342). Meyerson (1978) cites the commonly held belief of both professionals and paraprofessionals that "working with these patients is unrewarding and dull, that outcome is hopeless... that prestige is not available for working in programs directed toward these patients." In addition to the difficulty assessing accomplishment, Ratliff (1988) points to the subtle frustration mental health workers experience in trying to determine how much time is required in order to evaluate whether they are doing a good job as well as evaluate whether these patients are benefiting from their services.

Chronically mentally ill patients also bring unstable and erratic transferences to the treatment situation. This lack of predictability and patients' bizarre symptomatology, coupled with the professional's need to maintain attentiveness and be responsive and responsible all contribute to the stressful nature of the work. (Farber and Heifetz, 1982, Ross, et al., 1989).

In addition to the demanding psychological characteristics of this population, the persistently mentally ill are often from the most impoverished and "desperate" (Lewis,1980) section of society. They present with multiple and complex social problems. Given their limited or compromised ability to negotiate the various service systems, these individuals in turn frequently require assistance to obtain needed resources. Because of budget cuts and other fiscal and regulatory constraints, these resources have been greatly reduced in turn contributing to limits on authority and autonomy as well as restricting opportunities for advancement in salary and status.

Staffing has also suffered leading to such things as heavy client loads, extensive paperwork, limited continuing education opportunities and limited training programs and preparation. All of these realities contribute to and compound worker dissatisfaction and stress. They can ultimately lead to what Lewis (1980) has described as a "battered worker."

Choosing Mental Health Social Work

Notwithstanding the stresses of work with the chronically mentally ill, many social workers choose to work with psychiatric chronicity. In fact, Rapp and Hanson (1988) point out that they "constitute the largest group of professionals in mental health and seem to be represented to an even greater degree in community support program staffing" (p. 271). A more recent study, (Gibelman and Schervish, 1995), puts the number of social workers in not-for-profit mental health settings at 40.9%.

Social workers are committed to finding ways to cope successfully with the long term problems of their clients. Kadushin (1974) attributes this to their "dedicatory ethic." A related observation is that "social workers are essentially humanitarians. Their dominant approach is to help people in trouble" (Billingsley, Streshinsky, and Gurgin, 1966, p. 53). This attitude was confirmed in a more recent survey conducted by Werrbach and DePoy (1993). In an effort to provide relevant information to administrators and educators, the authors studied social work students' perceptions about working with the seriously mentally ill and the degree of congruence between future job satisfaction and the established features of this work. Describing their findings as "extremely hopeful," Werrbach and DePoy found that students reported feeling "challenged by the potential to work with persons who are not always cooperative" (p. 315).

Worksite Stress in Mental Health

In addition to the psychosocial stresses, which mental health professionals have been able to negotiate, the other major source of stress identified in the literature stems from the work environment of social service settings where chronically mentally ill patients are treated. It is this aspect of the work which is creating new problems for staff, but not in the way originally defined by researchers.

Traditionally, occupational stress referred to such concrete factors as poor physical working conditions, bureaucratic procedures and financial accountability demands favored over client needs, as well as role ambiguity and a lack of useful feedback and direction from superiors (Cherniss and Egnatios, 1978, Barber, 1986).

More recently, expanded views on worksite stress have emerged. Donovan's (1987) commentary is representative of current assessments. She contends that "definitions of occupational health and safety are expanding from an exclusive focus on hazards that affect physical health...to include the mental health hazards of stressful working conditions." She goes on to state that "...psychosocial stress in the work environment is emerging as a significant occupational hazard, reflected in the fact that many states now recognize emotional distress as a work-related illness..." (p. 260).

This more contemporary definition of work-related emotional stress underscores the compelling new problem facing mental health practitioners in their current work with the large number of their chronically mentally ill clients who now have serious and/or life threatening illnesses as a result of aging and drug abuse, and who are being seen in increased numbers as more and more are aging in the community.

Public Welfare Policy of Deinsitutionalization

The increased presence and visibility of physical disorders among the chronically mentally ill may be an unanticipated consequence of the earlier social welfare policy of deinstitutionalization. Prior to the 1950's, most chronically mentally ill patients became older, physically sicker, and died in psychiatric institutions. The wholesale release of mentally ill patients began in the 1950's and 1960's and continues into the present. One aspect of this policy was that ex-patients coming out of state hospitals would be discharged to community mental health centers which would now become responsible for their care.

Deinstitutionalization has created two patient populations with specific types of medical problems. According to Johnson (1990), in the 1970's and 1980's the major "large-scale depopulation of the state mental hospitals" involved "thousands of mental patients who were well over 40." (p. 108). Many of those patients were discharged to community residential care. They are now aging and becoming physically ill with what Brickner, et al. (1984) describe as "all the standard medical disorders including cardiac disease, diabetes mellitus and its sequelae, hypertension, acute and chronic pulmonary disease, tuberculosis, and cancer." (p. 242). Brickner (1984) also points out that patients with these kinds of chronic and life threatening medical disorders require disciplined dietary and/or medication management without which there could be serious complications and death.

A subset of this older population is made up of those deinstitutionalized people who chose to remain outside of the social service system. These are the homeless individuals whose years on the streets and poor hygiene have contributed to the development of many chronic physical health problems which are confounded by illnesses associated with aging. With the increase in housing funds during the 80's and 90's, many of these clients have entered the residential case system. This cohort of patients represents one of the two populations with whom the staff in this study routinely work.

The second population, which has emerged in recent years, includes, according to Lamb (1984), "a growing number of mentally disabled persons...who have never been or have only briefly been in hospitals.... They tend to be younger and often manifest less institutional passivity than the previous generation..."(p.63). This population is frequently dual-diagnosed with co-occurring major substance abuse disorders, and a significant proportion of these clients have AIDS, an illness with "complex biopsychosocial effects" (Davidson and Foster, p. 294, 1995). Also, as noted by Shernoff (1990), "working with persons with AIDS poses the challenge of working with some of the most disenfranchised and despised segments of our society" (p. 7).

Additionally, in contrast to the first group of mentally ill clients whose illnesses and deaths are usually related to aging, this second group of physically ill clients are either dying prematurely as a result of AIDS or have serious AIDS-related illnesses and are expected to die, but only after a prolonged and painful period.

This change in the physical health status and needs of the chronically mentally ill has major practice implications for social workers in mental health settings. Staff working in community based psychosocial programs may not have chosen to work with complex medical problems or bereavement issues in addition to chronic psychiatric disabilities. More likely, many specifically chose to work in the mental health field of practice rather than in medical social work. Given the current reality that more chronically mentally ill clients are living out their lives in the community and that these clients are aging and dying, they are presenting mental health staff with additional care needs which are different than what these practitioners may prefer to work with, are trained for, or are emotionally equipped to handle. Thus, the social workers who care for clients with this new profile are likely to be experiencing a new occupational strain that warrants attention.

In conclusion, the extensive literature on social work with chronically mentally ill clients documents that there have always been high levels of stress as well as emotional overload in this area of practice. Workers regularly deal with clients' feelings of anxiety, anger, depression, and despair as well as their bizarre symptomatology. The nature of the work is one of intensive involvement with clients over a long period of time, often with limited signs of improvement. There is also likely to be stress stemming from less experienced social workers' unrealistic professional role expectations about what constitutes effective or successful help. Consequently, a relatively new and unexamined problem facing mental health practitioners in their current work with chronically mentally ill clients is the increase in the number of clients who are diagnosed with serious and/or life threatening illnesses such as cancer and AIDS as a result of aging and drug abuse.

Because "the advent of AIDS... has heightened awareness of the difficulties inherent in death and bereavement work" (Davidson and Foster, 1995, p. 293), there is a growing literature both about the particular stresses in this area and about the development of support programs for the health care staffs caring for these patients. There is also attention to the needs of social workers in other high risk medical settings given that "few careers serve up more predictable, unrelenting stress than social work in health settings" (Dillon, p. 91, 1990).

Comparable attention has not been reported for the needs of mental health social workers whose clients are also medically ill. Formerly, staff working with the chronically mentally ill had to cope with the stressful event of an infrequent suicide (Ross et al.,1989). These professionals did not expect or even anticipate the current frequency and painful reality of so many clients dying.

Given the literature about the workplace stresses for medical social workers, it is hypothesized that the multiplicity of medical illnesses and deaths among the chronically mentally ill introduces a significant and unrecognized occupational strain which may have a serious and detrimental impact on the professional performance of mental health social workers.

The purpose of this dissertation is to explore qualitatively the experiences of mental health social workers in order to learn about how the changes in their clients' physical health status have affected them in their professional role. In addition to identifying and examining the factors considered to be stressful and demanding in this new work environment, the dissertation is intended to generate insight into how the mental health staffs handled this new professional demand as well as to illustrate what types of coping enhanced their practice with this population.

Chapter II

Review of the Literature

Introduction

The professional experience of mental health workers who serve a client population characterized by both mental illness and serious physical illness is likely to be inherently stressful. Therefore the literature on stress, coping behavior, and professional burnout appear relevant to the study reported here. These areas are covered first in this literature review. In addition, within the general topic of coping behavior, the specific literature on the stress buffering impact of social support and social competence is considered. Within the general area of burnout, the specific literature on job satisfaction is considered.

Stress

As used here, stress is defined as occurring when the individual "appraises a situation as threatening or otherwise demanding and does not have an appropriate coping response" (Cohen and Wills, 1985). While straightforward on the surface, this statement reflects complex developments and refinements in understanding about important linkages in the stress process.

In its original usage, in the physical sciences and biological medicine, stress most often referred to either a response of an organism to a noxious condition or the external, noxious force itself. This original description emphasized the unsettling demands on homeostasis made by change. Pearlin, Lieberman, Menaghan, and Mullan's (1981) discussion of the stress process reflects this early viewpoint.

> The natural state of the organism is one of equilibrium between the many inner and outer forces that it hosts. When a change occurs in one part of the organism, it is thought to create a disequilibrium among the other parts.
>
> This, in turn, imposes a period of readjustment during which the system struggles to reestablish a homeostasis. The struggle for readjustment can be wearing and exhausting, and under these conditions the organism becomes outstandingly vulnerable to stress and its physical and psychological consequences (p. 339).

"The development of interdisciplinary scientific thought, and with it the gradual emphasis on relations among systems and the importance of the context in which phenomena occur" (Lazarus and Folkman, 1984 p. 17) has enlarged the classical, biological understanding of stress. Discussions of stress now include sociological and psychological components, especially as these occur in or emanate from experiences within the social spheres of life such as work.

Social scientists were among the first to point out that not all change is inherently stressful. They cautioned that changing events are a necessary and unavoidable part of the life cycle. This recognition has lead to work that distinguishes events by such qualities as their desirability, predictability, and the degree of control the individual can exert over the situation or its solution (Pearlin, 1981, 1989).

Pearlin and his colleagues (1981) also noted that another element in the etiology of stress is self concept. They suggested that life events and chronic strains are particularly likely to lead to experienced stress when they result in a diminishment of one's self concept. They argued that the two aspects of the self concept that are most relevant in this regard are mastery and self-esteem. They defined mastery as "the extent to which people see themselves as being in control of the forces that importantly affect their lives," and they defined self-esteem as "judgments one makes about one's self-worth" (1981, p. 340).

The concept of mastery brings to mind the cognitive dimension of depression tapped by the Beck Depression Inventory (1957), which involves the perception that the negative aspects of one's life are beyond one's control and likely to persist into the future. This might be reflected in the perception of a mental health worker that the clients are not getting better, or in the perception that there is little prospect that the agency will be able to substantially improve the quality of services provided to clients. The concept of self-esteem could be reflected in the perception of the mental health worker that his or her professional efforts are ineffective. The workers' inability to ameliorate clients' problems or alleviate the pain and suffering associated with serious illness and death can erode self-esteem by becoming proof of professional failure or inadequacy.

Caplan (1981) also discussed the role of mastery in the etiology of stress. He defined mastery as

> behavior by the individual that (1) results in reducing to tolerable limits physiological and psychological manifestations of emotional arousal during and shortly after the stressful event and also (2) mobilizes the individual's internal and external resources and develops new capabilities in him that lead to his changing his environment or his relation to it, so that he reduces the threat or finds alternate sources of satisfaction for what is lost (p. 413).

Caplan emphasized that both of the elements in this definition are required for mastery. He argued that when emotional arousal exceeds a certain threshold of tolerance, it is likely to reduce the individual's effectiveness in responding to the environmental stressors. On the other hand, simply achieving an emotional state of relative comfort which is not accompanied by effective externally directed action may not prevent the occurrence of significant damage to the individual.

Lazarus and his associates (Coyne & Lazarus, 1980; Folkman, 1984; Lazarus, 1981; Lazarus & Folkman, 1984; Monat & Lazarus, 1991) built upon the idea that mastery plays a significant role in the etiology of stress, producing a theory of stress and coping that emphasizes the role of cognitive appraisal and coping as mediators of stress-related adaptational outcomes. Folkman (1984) used the word control rather than the word mastery in this context, defining control in two ways: "as a generalized belief of an individual concerning the extent to which he or she can control outcomes of importance and as a situational appraisal of the possibilities for control in a specific situational encounter" (p. 839).

Folkman emphasized that the cognitive theory of stress and coping is relational and process oriented. The relational aspect of the theory is emphasized in her definition of stress as "a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and as endangering his or her well-being" (1984, p. 840). She noted that this definition of stress distinguishes the cognitive theory of stress from approaches in which stress is defined as a noxious stimulus, approaches in which stress is defined as a product of intrapsychic conflict, and approaches in which stress is defined in terms of the individual's reactions in the form of physiological arousal or subjective distress. The idea that the cognitive theory of stress is process oriented has two meanings: first, that the person and the environment are in a dynamic relationship that is constantly changing, and second, that this relationship is bidirectional, with the person and the environment each acting on the other. The latter observation mirrors Caplan's (1981) observation that mastery involves both the individual's subjective reaction to a stressors, which in part determines his or her ability to respond, and the effectiveness of the individual's response, which in part determines how damaging the stressors may be.

Folkman (1984) noted that the individual's perception of a stressful event is determined by two forms of cognitive appraisal. These are primary appraisal, through which the individual evaluates the significance of a specific transaction with respect to the person's well-being, and secondary appraisal, through which the person evaluates coping resources and options. Assuming that primary appraisal of an event suggests the potential for harm, threat, or challenge, secondary appraisal addresses the question, "What can I do about it?" The answer to this question involves the assessment of available coping resources, which may include physical, social, psychological, and material assets. The balance between the appraisal of the severity of the threat and the extensiveness of the resources available for coping with the threat determine the individual's perception of control, or what Caplan (1981) referred to as mastery.

The cognitive theory of stress constitutes a paradigm that is highly appropriate to understanding the experience of mental health workers whose psychiatrically disordered clients are also seriously ill physically. The theory goes a long way toward explaining why work-related stressors may have very different effects on different mental health workers, depending on both the availability of coping resources and the individual worker's personal beliefs regarding mastery and self-esteem. These variables are reflected in the coping behaviors employed by workers, and ultimately in the effectiveness of these behaviors in minimizing the negative impact of the stressors encountered in working with this population.

Coping

Coping is considered a major moderator of stress. The concept refers to the "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus and Folkman, 1984, p. 141).

Coping is usually defined descriptively and has accumulated a number of conceptual meanings. Sometimes the term has been used interchangeably with kindred concepts like mastery, defense, and adaptation. At other times distinctions have been drawn. For instance, White (1974), saw adaptation as "the master concept" under which coping as well as defense and mastery "accept restricted meanings" (p. 47). Lazarus et al. (1974) explained these differences as follows:

> Under conditions of relatively low stakes to the organism, the focus tends to be on deliberate, flexible, reality-oriented, or rational efforts at mastery; in effect, on what is usually problem solving. When the context is that of strong drive frustration, stress, or emotion, that is, when the stakes are high, the focus is likely to shift to more rigid, primitive, less adequate, and less realistic efforts at mastery. Instead of *problem solving, coping and defense* (italics by author) are frequently used to describe the efforts at mastery in the latter context.

Regardless of the definition used, the functions of coping remain the same. Pearlin's (1989) distinctions are typical. He contended that all coping, regardless of the nature of the stressors, serves either to:

> change the situation from which the stressors arise, *manage the meaning* of the situation in a manner that reduces its threat, or *keep the symptoms of stress within manageable bounds* (p. 250).

Simply put, coping refers to any response to life-strains, either in the form of an action, thought, or perception, that serves to "prevent, avoid, or control emotional distress" (Pearlin and Schooler, 1978, p. 3).

The work done by these two authors has greatly enhanced our understanding of the structure of coping. In so doing they have also made it possible to be more strategic in building interventions. Pearlin and Schooler (1978) identified several facets of coping. They distinguished these as psychological resources, specific coping behaviors, and social resources.

Psychological resources are those personality traits which reside within the self. They are the characteristics which are innate to the person. Hamburg and Adams' (1967) statements attempt to define the nature of this aspect. They noted that

> there is a wide range of individual differences.... The appraisal of threatening elements rests heavily on their personal meaning--which in turn is strongly influenced by...dispositions that have become internalized. The salience of a given element to motives or values of the person and conflict among these motives or values is crucial to the individuals's threat appraisal (p. 277).

Various personality characteristics or "intrapersonal resilience" (Egan, 1993) are suggested in the literature. One example is Ben-Sira's (1985) proposal that people who are confronted by demands they perceive as stressful and beyond their coping ability but who are still able to maintain psychological health, have an internal resilience he calls "potency." This construct resonates with Pearlin and Schooler's hierarchy of positive internal resources, namely self-esteem and mastery.

A similar discussion of psychosocial resilience can be found in Rutter's (1987) description of the mechanisms that protect against psychological damage. Rutter believes in the importance of establishing and maintaining self-esteem and self-efficacy as well as opening up opportunities for learning risk reduction methods.

Kobasa's (1982) explanation for understanding this resilient predisposition have the most potential for understanding what constitutes stress resistance as well as what might enhance it. She developed a sociological and psychological framework for looking at the experience of stress in the workplace. Accordingly, Kobasa described the characteristic of "hardiness" which is composed of three components: commitment, control, and challenge. Commitment refers to the belief in the capacity of oneself and one's involvements. Control refers to the belief that one can control or influence situations or events. Challenge is based on a recognition that life changes and that meeting changes is an opportunity rather than a simple threat. In other words, the hardy person is active rather than passive, curious, tends to find experiences interesting and challenging, regards change as normal, and believes in their ability to be influential in the management of life's problems.

As proposed by Kobasa, this constitutional capacity affects the person's appraisal of stress so that the hardy individual copes by feeling competent and in control. There have been oblique references to this constitutional capacity in the healthcare social work literature. Vachon (1987) suggested that the health professionals who cope competently with death and dying work do so by controlling the meaning of the experience. In a similar vein, Siefert, Jayaratne, and Chess (1991) advocated helping healthcare social workers develop a sense of "mastery" and personal competence in order to moderate the stress of their work.

Lazarus and Folkman (1984) defined coping more broadly, emphasizing both the management of emotional distress and the specific actions taken to adapt to the stressors and restore homeostasis. They defined coping as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person."

The words "constantly changing" reflect the process-oriented nature of their cognitive theory of stress. The fact that the efforts conceptualized as coping are necessarily responses to threats that are appraised as taxing or exceeding the resources of the person implies a distinction between coping and automatized adaptive behavior. Routine adaptive behaviors that do not require specific effort (such as putting on a sweater when one is cold) are not considered coping behaviors. Thus coping is limited to behaviors that occur in response to psychological stress.

Coping Behaviors

A crucial aspect of this definition is the distinction between the coping behavior and the nature of the outcome. Coping refers to efforts to manage demands, regardless of the success or lack of success of those efforts. This definition differs from popular conceptualizations of coping, in which the term coping implies managing or succeeding, whereas not coping implies failure. Managing demands does not necessarily imply mastery. One may also manage demands by minimizing, avoiding, tolerating, or simply accepting stressful conditions as well as by attempts to master the environment.

In this formulation, coping is viewed as serving two major functions: the regulation of emotion (referred to as emotion-focused coping) and the management of the problem that is causing the distress (referred to as problem-focused coping). Folkman and Lazarus (1980) administered a 68-item coping strategy checklist to a sample of 100 adult men and women. This checklist required respondents to indicate which coping strategies they had used to deal with real life events that occurred during the seven months prior to the study. Examples of emotion-focused coping strategies included such items as "looked for the silver lining," "accepted sympathy and understanding from someone," and "tried to forget the whole thing." Examples of problem-focused coping strategies included "got the person to change his or her mind," "made a plan of action and followed it," and "stood my ground and fought for what I wanted." Their respondents mentioned over 1300 different stressful episodes, ranging from minor problems like car trouble to major problems such as the loss of a job or the diagnosis of a life-threatening illness. Folkman and Lazarus (1980) found that both emotion-focused and problem-focused strategies were employed in over 98% of the episodes described. Emotion-focused strategies were more likely to be used in situations that were perceived as not amenable to change, whereas problem-focused strategies were more likely to be used in situations that were appraised as changeable.

Pearlin and Schooler also saw coping responses representing the things people *do* as opposed to psychological resources which refer to what people *are*. Examples of these types of coping responses and their functional relevance are well documented in the health care literature. These include medical students' learned attitude of "detached concern" identified by Lief and Fox in 1963 and later discussed by Mizrahi (1986). Writing about social workers in oncology, both Davidson (1985) and Koocher (1979) also referred to a device of "limiting emotional involvement" (Koocher, p. 149). Koocher went on to discuss that when evaluating staff behavior, it was important to see this kind of withdrawal as a recognized coping mechanism which is affectively different from the emotionally flat disengagement characteristic of burnout. In defining this behavior, Koocher explained that "in the optimal circumstance the care giver is able to be empathic and responsive, yet retain enough emotional distance so as to avoid over involvement and over identification with the patient" (p.150).

More recently, writing about social workers' responses to the stress of working with AIDS patients, Wade and Simon (1993) described a phenomenon of informal but intense paired relationships which the authors call "survival bonding." In this problem focused type of coping behavior, staff actively sought out other professionals who shared their point of view with whom they could compare notes and share reactions and feelings.

Research conducted by Menaghan and Merves (1984) has concluded that individual coping is not especially effective in managing the stress found in occupational settings. Similarly, Pearlin and Schooler (1978) noted that occupational problems are often impervious to individual efforts. Their research led them to conclude that "there are important human problems, such as those we have seen in occupations, that are not responsive to individual coping responses. Coping with these types of problems may require interventions by collectivities rather than by individuals" (p. 18).

Burnout

The term "burnout" was coined by Herbert Freudenberger in 1974 to describe a complex of attitudes and behavioral symptoms he observed among staff in alternative care institutions. These include a lack of enthusiasm for one's work, a perception of the futility of one's efforts, exhaustion, the development of somatic complaints, and the emergence of a pattern of lateness and absences. Subsequently, the concept has been applied to both blue collar workers and white collar professionals. It is considered an important construct because it is believed to be "the precursor or indicator of dysfunctional job performance" (Gilbar, p. 39,1998).

The most prolific researcher of early burnout studies is Maslach (1986) who studied burnout among workers who provide healthcare and mental health services. She defined burnout as a "multidimensional construct" that is characterized by emotional and physical exhaustion, depersonalization of clients, and a diminished sense of personal accomplishment in one's work. She developed the Maslach Burnout Inventory, a self-report instrument that has been widely used in burnout research.

Several investigators have suggested that burnout is a particularly difficult problem for workers in the helping professions. Pines, Aronson, and Kafry (1981) argued that the performance of work which is emotionally demanding and draining is a significant source of stress among those with a "person-centered orientation." Edelwich and Brodsky (1983) suggested that "all helping professionals experience the first stages of burnout (a progressive loss of energy, idealism, and purpose) as they move from professional training to the real difficulties and limitations of their profession..." (pp.14-15). However they did caution that young workers are especially likely to have unrealistic expectations and that these expectations can lead to disillusionment and burnout unless they are addressed and modified during training. Courage and Williams (1987) stated that "burnout is the occupational hazard of the helping professions" (p. 7).

Ratliffe (1988) acknowledged that "burnout is not restricted to the helping professions," but she argued that "the frustrations experienced by these professionals make them particularly susceptible" (p. 148). However, she suggested that a special source of stress among social workers is the difficulty associated with measuring accomplishment or progress in order to determine if one is actually helping.

It has been argued that burnout is a particularly pernicious problem among health care workers. Beemsterboer and Baum (1984) suggested that burnout has existed for as long as work has existed, but they also argued that unique aspects of health service delivery work, particularly the intense emotional involvement with clients who are sick, put significant stress on workers that could lead to a loss of energy and purpose with "greater regularity" than may be the case with workers in other fields.

Nevertheless, the exact etiology of burnout is unclear. Stav, Florian, and Shurka (1987) studied burnout among professional rehabilitation social workers in several different rehabilitation agencies and among social workers in social welfare agencies. They reasoned that workers in rehabilitation settings might be particularly vulnerable to burnout, since they treat clients who are coping with loss and bereavement. However, they found no significant differences in measured burnout between workers in rehabilitation settings and those in standard social welfare settings. They concluded that "the sources of burnout cannot be evaluated in a one-dimensional study of a particular variable...but rather require systematic investigations of a variety of variables and factors that contribute to the phenomenon of professional burnout" (1987, p. 93).

The burnout paradigm provides the focus for much of the descriptive literature on health care workers who work with chronically and terminally ill patients and patients who have HIV or AIDS. Davidson (1983) pointed out that working with cancer patients may stir up in social workers "strong affective reactions" (p. 9) including overwhelming fears of their own mortality. Similarly, Koocher (1979) and L. Supple-Diaz and D. Mattison, (1992) described the phenomenon of over-identification that occurs among oncology social workers when they are working with dying patients of similar age, background, or when they have a personal history of loss or illness and that this may lead to powerful fears of death. Mor and Laliberte (1984) suggested that burnout among hospice workers is related to the terminal illnesses of their patients. Pilseker (1979) also referred to the constant exposure to the "dreaded sights, smells, and sounds" of physically ill patients as a potential source of burnout (p. 370). Ogle (1983) too concluded that the repeated intense interactions with people who are suffering makes health care workers prime targets for stress. Mailick (1991) argued that a sense of personal and professional helplessness lies at the root of the burnout experienced by healthcare social workers. Organizational constraints in hospitals (Foster and Davidson, 1995), and changes in the delivery of healthcare services and the attendant effect on the role of social work (Dillon, 1990) were also listed as sources of stress.

Health service providers who work with AIDS patients experience all the sources of stress noted in connection with workers who serve the chronically ill, but in addition they may experience fears of contagion, counter transferential homophobia, and discomfort discussing issues of sexuality. They may also experience stress in relation to helping young, socially stigmatized individuals who "live in a twilight zone" or "liminal space" and ultimately die "long, sad, hard deaths" (Bauer, 1990, p.233).

Supple-Diaz and Mattison (1992) argued that the "definitions of burnout are often ambiguous" (p. 114). Beemsterboer and Baum (1984) went so far as to suggest that the term burnout "has been expanded beyond its utility so that it has become a catchall...expression" (p. 97). Indeed, they suggested that burnout has become a "smoke screen" providing a label for a large number of other conditions and symptoms and that there is "a lack of a thorough understanding of the concept" (p. 103). However, they do suggest that burnout is a process that is experienced by degrees, and they argue that burnout results from both work-related conditions and from other influences which exacerbate the impact of these conditions, including social and economic difficulties, family and personal problems, and organizational difficulties.

Job Satisfaction

Given that one of the three conceptual domains comprising the construct of burnout is lack of personal accomplishment, it would appear axiomatic that job satisfaction would be related to burnout. One suspects that workers who are attempting to cope with the demands of clients who have both psychiatric problems and serious physical illnesses will experience frustration with respect to their very limited ability to improve their clients' lives. However, one also suspects that pleasant working conditions, good pay, good colleagial relationships, opportunity for promotion, and adequate administrative support could go a long way toward giving workers a sense of accomplishment, even in the face of frustrations associated with the seriousness of the clients' problems. Thus "nonstress" variables associated with the workplace, factors that are extrinsic to the work itself, might also be expected to mitigate burnout.

This conclusion is supported by findings reported by Jayaratne and Chess (1983) who studied a random sample of 853 NASW members. They found that 35.4 percent of their sample reported being very satisfied with their jobs, and another 46.3 percent reported that they were somewhat satisfied. This relatively high level of self-reported job satisfaction was found in spite of the fact that the workers surveyed also tended to indicate that they were overworked (role overload), that they were frequently unclear regarding what they should actually be doing (role ambiguity), and that they were sometimes asked to perform tasks that appeared to be contrary to the fundamental professional goal of helping people (role conflict). Jayaratne and Chess (1983) also found a negative relationship between job satisfaction and burnout.

Courage and Williams (1987) presented a model for predicting stress and burnout among mental health professionals that explicitly recognizes both the intrinsic nature of the work and the extrinsic rewards associated with a specific employment situation. They considered the characteristics of mental health professionals, the characteristics of the organizations they work in, and the characteristics of the clients they serve. This conceptualization is also highly relevant to the present study. In analyzing the content of the focus groups conducted with the mental health workers in the agency studied, the investigator sought to identify comments concerned with both the intrinsic nature of the work with clients and the extrinsic rewards of employment.

Social Support

"Social" refers to specific social resources which the individual can draw upon in the process of coping with stress. There is not a one-to-one correspondence between one's social network and social support as a coping resource. Social support is a function not only of the extensiveness of one's social network, but also of the level of concern, trust, and intimacy which characterizes that network.

Thoits (1987) defined social support as

> the degree to which a person's basic social needs are gratified through interaction with others. Basic social needs include affection, esteem or approval, belonging, identity, and security. These needs may be met by either the provision of *socioemotional aid* (e.g. affection, sympathy and understanding, acceptance, and esteem from significant others) or the provision of *instrumental aid* (e.g. advice, information, help with family or work responsibilities, financial aid (p. 145).

Cohen and Wills (1985) suggested that social support has both a direct effect on individual well-being and an indirect effect by buffering the impact of stress. The direct effect of social support derives from the fact that "large social networks provide persons with regular positive experiences and a set of stable, socially rewarded roles in the community...as well as a sense of predictability and stability in one's life situation, and a recognition of self-worth" (p. 311). The indirect buffering effect of social support derives from the perception that others can and will provide resources which will bolster one's ability to cope with stress or find a solution to a problem.

Several quantitative studies have demonstrated the stress buffering effect of social support. Koeske & Koeske (1989) studied social work students and found that social support buffered the relationship between workload and burnout. In a study of psychologists working in counseling centers, Ross, Altmaier, and Russell (1989) found that supervisory support mediated the relationship between workload and burnout. In a study of human service professionals in Norway and in the United States, Himle, Jayaratne, and Chess (1991) found no evidence that social support of an emotional nature, derived from co-workers or from supervisors, buffered the effect of occupational stress on burnout. However, social support of an instrumental nature and social support of an informational nature did have the expected buffering effect.

Where research has failed to demonstrate that social support has a significant mediating effect on the relationship between occupational stress and measured burnout, the investigators have typically failed to employ valid and reliable measures of social support. Thus Thoits (1987) pointed out that "most investigators have not attempted to formulate a precise conceptual definition of social support, and few have attempted to develop valid and reliable indicators of this concept" (p. 146). Similarly, Bronstone (1993) recommended that researchers need to use more "precise, reliable, and valid measures of social support" that are informed by theory (p. 60).

Social Competence

Social competence is another concept which offers a possible explanation for the effectiveness of social support. In line with Caplan's (1981) concept of mastery and the concept of control put forth by Lazarus and Folkman (Folkman, 1984; Lazarus & Folkman, 1984), social competence has been used to explain why some human service professionals experience greater levels of stress and burnout than others (Corcoran & Bryce, 1984; Harrison, 1983; Himle et al., 1991; Streepy, 1981).

Streepy (1981) studied self-perceptions and burnout among social workers. He found that workers who saw themselves as skilled clinicians tended to experience lower levels of burnout than workers who viewed themselves as less skilled. Based on this finding, Streepy concluded that it is imperative that social workers be provided with sufficient education and training so that they come to perceived themselves as competent professionals who possess a specific body of skills that can be applied effectively to the problems they encounter on the job.

Corcoran and Bryce (1984) provided some empirical evidence of an inverse relationship between measured burnout among social workers and self-perceptions of interpersonal skills. These investigators provided in service training in interpersonal skills to social workers. There were two different training modalities, an affective-oriented training module, and a cognitive-oriented training module. The investigators measured burnout, using the Maslach Burnout Inventory, before and after the training interventions. They also measured burnout pre- and post-training among a group of matched controls. Corcoran and Bryce (1984) found that skills training did have an impact on burnout. The affective-training module was particularly effective in reducing the emotional exhaustion component of burnout. They concluded that skill development is an "insulator to burnout" and that "skill development would inhibit burnout" (p. 77).

Harrison (1983) presented a somewhat broader "social competence model" of burnout among human service professionals. This model emphasized not only the worker's self-perception as having skills, but also the perception that their efforts have a positive impact. Harrison emphasized that human service professionals are motivated primarily by the desire to help others, and he suggested that the perception that one is actually helping other human beings goes a long way toward preventing burnout. Harrison stated that not all human service workers inevitably burn out. He suggested that those who do not burn out believe that "what they do is valuable and makes a difference in the lives of clients" (1983, p. 42).

Harrison also noted several conditions or factors which may contribute to the worker's sense of personal competence. These include factors that pertain to the worker, including perceptions of one's knowledge, skills, and professional judgment that are developed through training and feedback. However, these factors also include aspects of the client population. Thus Harrison concluded that "the objective reality of the client's problem has to be included in the...equation" (1983, p. 35). This observation is obviously relevant to the present study, since many of the clients served by the mental health workers studied here have chronic, serious, life-threatening illnesses which the workers have relatively little opportunity to alter. This situation, coupled with the pain and suffering experienced by many clients, might well leave workers feeling ineffective, leading to burnout.

Himle et al. (1991) also incorporated the concept of social competence into their explanation of the buffering effect of informational and instrumental support on burnout among social workers. They argued that workers who have been provided with information that is helpful to their work and workers who are provided with instrumental support will in fact have a greater ability to improve the lives of their clients, and this enhanced capability will naturally be reflected in self-perceptions of social competence. Thus, Himle and associates are suggesting that both the ability to have a positive impact and the improved self-perceptions associated with this ability tend to ameliorate worker burnout.

Conclusion

The literature on stress, coping, burnout, and job satisfaction is clearly relevant to the group of professionals studied in this project. These mental health workers serve a population with very serious problems, both mental and physical, many of which the workers are unable to ameliorate. Additionally, while these workers may have found ways to cope with the psychiatric disorders of their clients, the clients' co-occurring physical illnesses present new demands requiring new responses.

The extent to which these workers derive satisfaction from what they can do for clients must be balanced against the frustrations associated with what they cannot do. Into this mix one must factor the potential buffering impact of such factors as social support derived from colleagues, friends, and family. One must also consider the workers' self-perceptions as skilled and competent professionals, as well as the extrinsic rewards associated with their employment situation.

In contrast with several of the quantitative studies cited above, the great advantage of a qualitative study of social worker stress and coping is that the workers tell us in their own words the most critical aspects of their experience with their work with their client population. The factors they emphasize should provide an indication of the relative importance of physical illness in their work with the mentally ill.

Chapter III

Methodology: Rationale and Program Design

Introduction

This chapter describes the methodology used in the study. It states more explicitly the purpose of the study and explains the rationale for the selection of a qualitative study design. The chapter also discusses and describes the sample, how the data were collected, and the method of data analysis.

Purpose of the Study

The purpose of this study was twofold. The first objective was to learn more about the experiences of mental health professionals working with chronically mentally ill clients who have co-existing physical illnesses. Secondly, in addition to identifying how clients' physical health status has affected the professionals who work in this changed practice area, the study generated insight into what contributes to effective coping for these social workers.

Rationale For a Qualitative Study Design

Because I planned to pursue an unexplored area of practice with no prior research findings, I used a qualitative methodology for exploratory data gathering and analysis that would yield insights and build theory through the generation of emerging data. For such purposes, Strauss and Corbin (1991) underscore the suitability of this method noting that "qualitative methods can be used to uncover and understand what lies behind a phenomenon about which little is yet known...and give the intricate details of phenomena that are difficult to convey with quantitative methods." In fact, the term "qualitative" implies that the various techniques used are generally "intended more to determine what things exist than to determine how many such things there are" (Walker, 1985, p. 3).

The appropriateness of qualitative research for the present research, where this investigator will get close to the people under study, is also emphasized by Lofland and Lofland (1971). They suggested that the four "people-oriented mandates" of qualitative research include being close enough to have personal understanding of the people being studied, capturing actual events and statements, describing interactions and activities, and including direct quotations" (Cited in Patton, 1990, p. 32).

Patton underscored the fact that qualitative research is distinguished by its "emphasis on inductive strategies of theory development in contrast to theory generated by logical deduction from a priori assumptions" (p.66). He noted that the researcher "attempts to make sense of the situation without imposing preexisting expectations on the phenomenon or setting under study. Inductive analysis begins with specific observations and builds toward general patterns" (p 43). At another point he commented that

> The strategy of inductive designs is to allow the important analysis dimensions to emerge from patterns found in the cases under study without presupposing in advance what the important dimensions will be. The

> qualitative methodologist attempts to understand the multiple relationships among dimensions that emerge from the data.... In short, the inductive approach to evaluation means that an understanding of program activities and outcomes emerges from experience with the setting (p. 44).

One such inductive method is grounded theory which "is inductively derived from the study of the phenomenon it represents" (Strauss and Corbin, 1991, p. 23). These authors pointed out that grounded theory procedures "build rather than only test theory... and provide the grounding, build the density, and develop the sensitivity and integration needed to generate a rich, tightly woven, explanatory theory that closely approximates the reality it represents" (p. 57). Strauss and Corbin also referred to grounded theory as both a type of qualitative research and a distinct set of concepts that are inductively derived from the phenomenon studied.

In another reference that is relevant to the fit between this project and qualitative research techniques, Patton also discussed grounded theory. He commented that in this type of "theory-method linkage,...grounded theory depends on methods that take the researcher into and close to the real world so that the results and findings are 'grounded' in the empirical world" (p. 67).

Rennie et al. (1988) cautioned the grounded researcher not to get involved in pre-investigation and analysis reading on their area of study. They pointed out that "in terms of practice, grounded researchers generally avoid reading pertinent literature until the investigation is finished and their grounded theories are in place. Once a theory is set, existing theories are evaluated and those that fit the grounded theory are integrated with it so that it may be further enriched and elaborated" (p. 141). Consequently, the absence of prior research in this area made qualitative research all the more appropriate.

There are other researchers whose views on this subject differ. Patton noted the importance of "sensitizing concepts" as a way of orienting fieldwork. He in fact saw group process as a construct which can provide such a "basic framework highlighting the importance of certain kinds of events, activities, and behaviors." (p. 216). Glaser and Strauss (1967) also argued that "the researcher does not approach reality as a tabula rasa. He must have a perspective that will help him see relevant data and abstract significant categories from his scrutiny of the data." (p. 3).

Mindful of the problems presented by pre-study information, I believe that clinical training furnishes professional objectivity and enables openness to the emerging material. Additionally, an independent reviewer can reinforce objectivity and neutrality in the analysis of the data. I also incorporated Strauss and Corbin's (1991) recommendations for both coding procedures and data analysis techniques which will also enhance theoretical sensitivity.

The Use of Focus Groups

The primary instrument used for collecting data in this inductive effort was focus groups. The nine groups run were audio taped for subsequent transcription, coding, and content analysis. Groups were conducted with a purposive sample of mental health staff, both social workers and case aides, working at Vistas (pseudonym), a large, urban, human services agency that provides a range of social services to persistently mentally ill individuals. Mental health professionals in two distinctly different but representative settings in the agency participated in the study: community residence personnel and staff in the continuing day treatment setting.

The focus group was selected because this format is consistent with the objectives and purpose of this type of research. Morgan (1988) noted that the "most common purpose" of focus groups is for exploring a topic about which little is known. Also, focus groups enable the investigator "to get closer to participants' understanding of the researcher's topic of interest" (Morgan, 1988, p. 24) another important component of qualitative research.

Moreover, the topic of workplace stress is of mutual interest to the participants as well as the researcher. Therefore, unlike participant observation or individual interviews, the other main qualitative methods, the interaction in the focus group has unique potential. There is the possibility of fostering constructive group discussion among participants as well as "new learning about their experiences and perspectives," in the form of self reported behaviors, rather than just their attitudes or opinions (Morgan, p. 23). Furthermore, Morgan pointed out that while focus groups are useful when it comes to investigating *what* participants think..., they excel at uncovering *why* participants think as they do" (pp. 24-25).

The focus group format provides other benefits. Group interaction may generate ideas which would not have occurred to any one individual. Also, it is possible that the interactions between the group members may result in or constitute evidence that is itself relevant to the study's substantive inquiry. In other words, participants' reports about their experiences in the focus groups may offer useful insights into the supportive potential of a peer group as part of an intervention program. This potential is supported by Walker's contention that the focus group itself "may prove to be a heuristic experience for the participants" (p. 5).

On a pragmatic level, focus groups served the needs of the agency as they were a more efficient use of staff time. Also, each team already had regular meetings times for administrative purposes that could be used for the study. Lastly, the staff in Vistas are familiar and comfortable with a group format and also with each other. These factors could potentially support an atmosphere where feelings and behaviors could be more easily disclosed and discussed.

Although the group format was open-ended to build a grounded theory, there was a "topic guide" (Hedges, 1985) in the form of a series of questions to steer the flow of the discussion. The topics to be covered were derived from deductive theory that provided an orientation together with recommendations made by several researchers who emphasized the importance of an organizing focus for inquiries on social work stress and job satisfaction. Based on reviews of the previously noted literature on stress identification in healthcare settings, all of these authors see personal, organizational, patient-related factors and a history of personal loss as the primary stress producing agents.

Pilot Group Study

Initially, on the belief that mental health professionals were unprepared to work with mentally ill clients who also had serious physical illnesses, I planned to study the viability of a peer support group to address staff reactions to client deaths. In January and February of 2000, I met with four mental health professionals, 2 social workers and 2 case managers, from a large social service agency serving chronically mentally ill clients for eight weekly, one hour group sessions in which they discussed their work with clients who were simultaneously physically ill and/or dying. This pilot study proved to be enormously helpful in shaping the present dissertation. Most importantly, it revealed that the professionals were struggling emotionally with the physical illnesses of their clients as well as client deaths.

The pilot project also crystallized the idea of the need for an exploratory study to first identify the nature of social work practice with this population and the ways in which staff cope with the potential stresses. Only then could an interventive program be developed to meet the needs articulated by the study.

Description of the Sample

The staff in the pilot project worked in several of the agency's single-site community residences. For the dissertation, I decided to study a sample of staff working in the agency's various continuing day treatment programs (CDT) as well as staff in several of the community residences. Taken together the two types of settings would be more representative of the total staff. This wider net could then potentially yield more information about the nature of this worksite stress, as well as the range of coping patterns.

This sample configuration also had the potential to yield information about the nature of organization-client relations at Vistas and the role these relationships play in the degree of stress experienced by staff. Lefton and Rosengarten (1974) have suggested that there are differing orientations of human service organizations toward the clients they serve and that these differing orientations affect the interpersonal processes between the clients and the professional staff. The authors hypothesize that an organization's interest in its clients may vary along two major dimensions. In a lateral orientation, the client has a "highly truncated" relationship with the agency which, in turn, "has an interest in only a limited aspect of the client as a person." A longitudinal orientation implies a long term relationship during which an organization would "have an extended interest in who the client is as a product of and participant in society" (p. 474).

The ages of the staff in the residential programs ranged from 27 to 68 with a mean age of 50. The staff in the CDT programs were from 23 to 68 years old with a mean age of 42. The average number of years working in mental health was 8 years for residential staff whose educational levels included 4 MSWs, 7 Bachelor of Arts, and 4 High School graduates. CDT staff worked an average of 12 years with the following educational levels: 5 MSWs; 5 Bachelor of Arts; and 4 High School graduates. 11 of the 15 residential staff indicated that working with chronically mentally ill persons was their professional choice. When asked how they would describe their work with clients who had both mental and physical illnesses, 12 stated that they found the work "much more stressful" than working with clients who only had mental illness while 3 felt it was "slightly more stressful." Of the CDT staff, 12 out of 14 indicated that they had chosen this particular practice area. This group were evenly divided in their assessment of the nature of the work, with 7 describing it as "much more stressful" than working with clients who had mental illness only, and 7 finding it "slightly more stressful".

Description of the Sample Selection

There was a two tier selection process. Staff in the agency's various day treatment programs were sent an introductory letter inviting them to orientation meetings set for a day that coincided with their regular staff meetings at the agency's main headquarters. Similar letters were distributed at each residence announcing orientation meetings. The meetings were arranged at a time when there was the most staff overlap given the 24 hour coverage. This "pregroup public phase," (Hartford, 1971) was intended to develop a purposeful, intensity sampling of information rich cases.

At each orientation meeting or "pregroup convening" (Hartford, 1971) session, I discussed the project's purpose and goals, individual members' needs, expectations and objectives, group structure, functioning, and content following Kurland's (1978) recommendations in her "Model of Planning for Social Work with Groups." These meetings also stressed that the study would be conducted in accordance with the guidelines established by the Hunter College Committee for Protection of Human Subjects for Research Risks Institutional Review Board. Participants were assured of confidentiality and anonymity as well as their right to withdraw at any time during the group. They were also asked to honor the confidentiality of the group process.

Lastly, the researcher provided the potential participants with a reading list of resources and a list of social work professionals experienced in working with illness-related problems should the group experience precipitate any negative reactions. At the end of each meeting a second time was set for the focus group. At that time participants were asked to sign informed consents.

Each subsequent day treatment group had 4 or 5 participants. The residential groups had between 4 and 6 participants. While these numbers are appropriate for a group experience, the smaller number of cases reduced this study's validity and generalizability. Patton (1990) referred to small sample size as a weakness of qualitative study. But he noted that the richness of the detailed information and the understanding obtained balances this limitation.

Patton also stressed that the validity as well as the reliability of qualitative data depend on the researcher's skill in doing systematic and rigorous observation. He emphasized that "content analysis requires discipline, knowledge, training, practice, creativity, and hard work" (p.11). As noted above, I felt that my years of clinical work with groups coupled with professional discipline would assist in developing "useful and credible" findings.

Description of the Setting

Vistas is a large, urban, not-for-profit, social service agency. This agency offers rehabilitation and supportive programs including case management; mental health services (individual and group therapy); socialization groups; vocational and educational programs (job training and placement in competitive employment); social, recreational, and creative arts activities, and primary health care services. There are also 12 single site community residences with an average of 18 residents per unit. Each site has 24 hour, seven day a week staffing. Agency housed clients are expected to attend day treatment. Individuals who live independently can and often do use the agency's services.

Methods of Data Analysis

The tape recordings of the focus groups were transcribed for subsequent analysis. The transcribed data from the focus groups were analyzed according to established procedures of qualitative research in order to identify common themes expressed by the participants as outlined by (Bogdan and Biklen, 1982; Graue and Walsh, 1998; and Strauss and Corbin, 1991). Thematic analysis begins with the identification of content coding categories within the transcribed data. Coding categories constitute a system for sorting the comments of focus group participants, so that material bearing on particular topics can be distinguished.

Bogdan and Biklen (1982) have described the process of developing coding categories as follows:

> You search through your data for regularities and patterns as well as topics your data cover, and then you write down words and phrases to represent these topics and patterns. These words or phrases are coding categories (p. 156).

Bogdan and Biklen (1982) further suggested that some coding categories will come to mind during the process of data collection, while others emerge as the data are reviewed. When the data have been organized into coding categories, the researcher proceeds to examine the categories to determine the logical connections that exist between the categories. These connections are what then lead to the emergence of themes.

Tesch's (1990) series of ideas and guidelines for the process of data analysis were also helpful. These recommendations include:

(1) Data analysis is concurrent with data collection and is cyclic. Analysis begins with data collection and becomes integrated with data collection.

(2) The process of data analysis is systematic but not rigid, and the process ends when the data no longer yield new insights.

(3) The process of data analysis is a reflective activity, and the researcher keeps notes on the process of data analysis in which she records her insights and observations as they occur. These notes facilitate the movement from the description of coding categories to the identification of themes.

(4) Analysis begins with the reading of all the data several times to achieve a "sense of the whole" that informs the interpretation of the individual elements.

(5) Data are segmented, i.e., divided into meaningful units that can be placed in content categories.

(6) The data segments are categorized according to a system of content coding categories that are derived from the data themselves.

(7) The main intellectual tool used in the data analysis is comparison. This is involved in creating categories, summarizing the content of categories, and identifying segments that do not fit any category. The goal is to uncover conceptual similarities and identify patterns.

(8) Categories remain flexible and modifiable throughout the process in order to accommodate new data.

(9) Manipulating qualitative data is an eclectic activity. There is no right or wrong method. Each researcher must develop her own process.

(10) The result of the analysis is a higher level synthesis, such as a description of the themes or patterns represented in the data (Tesch, 1990, pp. 96-97).

Additionally, Tesch (1990) suggested that the investigator records content coding categories and tallies these categories as they reappear throughout the data. When all the data segments have been coded, the coding categories are scrutinized to determine whether any of the categories can be collapsed or related to each other so as to form themes. These themes will then be described in detail and illustrated with quotes and descriptions of behavior.

Strauss and Corbin (1991) described a similar series of steps to be followed by the investigator when analyzing data elicited from open-ended interviews. They suggested that the qualitative researcher should:

(1) Listen to the tape recordings of the interviews several times, while maintaining field notes to record initial reactions.

(2) Transcribe the interviews.

(3) Read and reread the transcribed interviews several times, continuing to record reactions in field notes.

(4) Perform open coding on interview transcripts, inserting codes into the text of each interview in **bold face type** as they occur to the investigator. (The term "open coding" refers to the fact that the investigator is not seeking to identify utterances that reflect predetermined content categories, but rather is seeking to identify any concepts which emerge in the interview, regardless of their content.)

(5) Have peers review the open coding, suggesting such additional codes as may occur to them.

(6) Discuss the suggestions of peers with them or other peers, and modify the open coding accordingly.

(7) List the codes developed from the first to the last in a place separate from the transcripts.

(8) Group the codes into content-related, thematic categories.

(9) Construct a frequency distribution for the thematic categories, indicating the number of times each category was represented as a code in the original open coded transcripts.

(10) Identify the conceptual relationships among the thematic categories, so that the categories can be described in a narrative that flows and promotes the readers' understanding of the participants' experience.

Potential Challenges to the Study's Validity

There were at least two potentially problematic challenges to research validity and reliability.

The first involved the fact that I am the wife of the agency's Executive Director, Emeritus, a reality known by all of the participants. This dual status presented a potentially serious problem. I believe, however, that my long history of consultations with various staff at the agency following client deaths helped to offset any difficulties. As a result of the staff members' "positive" experiences over the years, there was a built-in, strong level of trust and acceptance regarding confidentiality and my sincere intent.

Notwithstanding this positive reputation, the issue of confidentiality was acknowledged and reinforced at the preliminary information meetings with prospective participants and at the beginning of every focus group.

Rosalie Wax's (1971) very pragmatic thoughts on the subject of entry into fieldwork further support the notion that the researcher's professional history helped develop these participants' trust. Noting that "most sensible people do not believe what a stranger tells them," she gives the following advice:

> In the long run, his hosts will judge and trust him, not because of what he says about himself or about his research, but by the style in which he lives and acts, by the way in which he treats them. In the somewhat shorter run, they will accept or tolerate him because some relative, friend, or person (in this case other staff) they respect, has recommended him to them (p. 365).

The second challenge to validity had to do with my extensive clinical experience in health care social work, and in particular with the psychosocial effects of serious physical illness on patients, families, and staff. When taken together with the deductive concepts that oriented the study, there was the potential for bias in both data collection and analysis. This problem was referred to in the earlier discussion on qualitative research where the cautions of several authors regarding theoretical preconceptions and biases were discussed. The authors' suggestions regarding ways to guard against such interferences led to my decision to have an independent evaluator review my data analysis to offset any potential bias.

Conclusion

This chapter has outlined the methodology used for this dissertation. After explaining the purpose of the study and the reasons for the selection of a qualitative study design to capture information about the experiences of mental health professionals who are working with chronically mentally ill clients with co-occurring physical illness, the chapter also described the sample and setting, how the data were collected, and the method of data analysis used.

Chapter IV

The Impact of Mental Illness: Managing Clients' Medical Care

Introduction

Social workers who choose to practice in mental health settings often indicate that they are motivated by a desire to help their clients' improve their functioning and live better lives. Because so many chronically mentally ill clients now have co-existing physical illnesses, helping clients live better and longer now includes helping them stay healthy physically as well as mentally.

Because of their psychiatric disorders, however, it is likely that clients often thwart these goals. This chapter will focus on understanding the ways in which clients' mental illnesses hamper adequate care and as a result add new demands on the professional staff.

Review of the Literature

Brickner, (1984), underscored the problems involved in managing the medical care of the chronically mentally ill when he spelled out what is required of individuals who are receiving treatment for medical conditions:

> Management of patients with chronic physical illnesses is a difficult task for health workers in the most favorable of circumstances. The ability of people living normal lives to cooperate with complex medical regimens, dietary restrictions, and other compromises to an unfettered life style is often poor, and yet we feel that adherence to these therapeutic plans is essential to

> disease control and recovery. By adding mental illness as a factor, the entire treatment structure becomes vastly more complex (p. 244).

One of the things that creates the complexity to which Brickner refers is the very nature of psychiatric illness. This has been well documented in the social work literature which describes the work with chronically mentally ill individuals as "emotionally demanding" (Aker, 1999). The reasons cited include regressive and inappropriate behavior and severe character disorders that limit the development of a therapeutic relationship (Cancro, 1983, Golub, Narducci, Frohock and Friedman, 1993) along with limited insight and poor judgment (Bland and O'Neill, 1990), apathy and negativism(Telson and Cucuo, 1993), slow progress in treatment and difficulty measuring improvement which can foster a sense of failure in the clinician (Maslach, 1978, Ratliff, 1988).

An earlier review noted that there is literature suggesting that notwithstanding these obstacles, social workers who treat the chronically mentally ill are committed professionals who have found ways to cope successfully with the long term mental health problems of their clients. The reasons given are their "dedicatory ethic" (Kadushin, 1974) and their "humanitarian need to help people in trouble" (Billingsley, Streshinsky, and Gurgin, 1966, p. 53).

A recent study of the impact of mental illness on social workers' professional performance goes even further in explaining the level of satisfaction that has been identified (Aker, 1999). The author speculates that "social workers during their socialization to the profession have acquired sufficient knowledge pertaining to treating clients with serious mental illness. Their expectations about working with this population may be realistic because they...do not expect these clients to improve significantly in treatment" (p.115).

Furthermore, there is literature which indicates that social workers who work with the seriously mentally ill feel "positively challenged by the potential to work with persons who are not always cooperative" (Werrbach and DePoy, 1993, p. 315). For example, in their discussion of a hospital based, outpatient psychiatric program, Golub, et al. (1993) described the "frustrating management of antipsychotic medication administration" (p. 109) and of the ways the staff found to successfully and creatively work with their clients.

There are however ways in which the combination of the "mental illness factor" and clients' lack of cooperation have created new problems for Vistas' staff. The reasons for these problems appear to lie in the parental character of the relationships staff have with their clients coupled with their concerns about the dire consequences that can occur as a result of psychiatrically induced noncompliance with medications and medical regimens.

Focus group discussions contained numerous references regarding clients' attitudes and behaviors toward general medical care that are consistent with difficulties reported in the psychiatric literature. Things like "limited, concrete thinking, schizophrenia, and severe personality disorders" that interfere with clients' willingness to be cooperative, impaired judgment because "internal voices disrupt their ability to follow a medical treatment plan" and "difficulty retaining and following through" on instructions and/or information regarding required medications and medical appointments all limit clients' capacity to manage their own care and contribute to serious noncompliant behavior that interferes with and complicates the staffs' efforts to help them.

However, the participants in this study represent a group of mental health professionals who now find themselves in the unanticipated position of supervising the management of their clients' physical needs as well. Consequently, there are demands on the staff related to the intermingling of medical needs and psychiatric illness coupled with the intense parental relationships staff have with their clients which are specific to the mental health setting These include a heightened, if reluctant, sense of responsibility and "mission" for managing clients' medical conditions in order to keep them alive, insufficient or nonexistent training that is necessary to handle this added task, and continual frustration and feelings of inadequacy because caring for clients' medical needs interferes with providing the services these staff are trained for, and therefore equipped to handle.

This chapter will discuss the stresses associated with the impact of clients' mental illnesses on the management of their medical needs and provide examples from the content of the focus groups.

Mental Illness and Noncompliant Behavior

There were numerous illustrations in the focus groups of how clients' mental illnesses "handicap them" often resulting in noncompliant behavior. As one worker noted, "It's hard to get them to understand. They will take their old psychotropic medications but not ones for a new illness." Similarly another staff person pointed out that "They just don't get it, how serious and dangerous it is that they have a certain physical illness."

Examples include a client telling his counselor that "We're not that sick" as he refused to go to his medical appointment and a paranoid client refusing to take medicine because he believed the medicine was part of a "conspiracy" against him. There was the 40 year old asthmatic client who had to take Prednisone on a regular basis. In this case a disordered life style as well as disordered thinking combined to effect his medical care:

> You have to be very specific with this drug. And due to his mental illness, he couldn't keep the medication straight...when to take it...how to take it. So it was very hard for me to keep track of whether he was taking it or not. So I spoke to his doctor and wrote out exactly how it was to be done. His sister had a copy, and still it got botched up. He was in Scattered Site, so sometimes he would stay at her house. But then he would forget to take it with him for two days. He was going back and forth, which added to his confusion. So I had to speak to the doctor about where do we start now, because you have to slowly decrease on Prednisone. Now we moved him back to a community residence because, based on that and some other things, he's not really capable of being on self-meds.

In describing his concern about a client's inability to follow instructions because of his mental illness, a supervisor presented the situation of one man, described as having the "abilities of a ten year old" who was a borderline diabetic and also has kidney dysfunction. This client was to begin 4 hours of dialysis on an every other day basis the following month. The case manager had begun preparing the client by writing him a note to keep as a reminder. He also planned to accompany the client for the first visit. After that he would have to go by himself. The worker noted with much frustration that "even though it's just up the road and no distance at all, it will be a miracle if he does it every time".

Staff Frustration with Client Non-Compliance

Several reported incidents not only illustrate the linkage between mental illness and noncompliance with medical care but also how frustrated the staff often feel as a result. The following incidents convey the frustrations created by the interplay of illnesses. In one instance a worker reported that:

> My biggest problem is a client who has lung cancer. He just had radiation and he also had surgery. Now he's refusing chemotherapy to prevent recurrence because he's very paranoid and he believes God does not want him to do it. So, he won't do it. Chances are his cancer is going to come back. So, we're having to chase him around to keep his appointments and make him go.

Then there was the client who

> won't take enough of her medication. She's laughing at the lights and the lights are talking to her and she is out buying a giant ice cream cone and we have LONG sessions and I plead with her. I put my heart into her telling her what is OK and what is Not OK and it is absolutely frustrating and useless!

The following discussion also highlights the frustration staff experience trying to help their severely disturbed clients manage their physical illnesses when they "are fighting me every step of the way and it feels like "you are beating your head against a wall." A staff member described feeling " hamstrung" by a client's erratic behavior. This was a client who had a positive Pap smear last year:

> Now a student is taking her for an appointment but she wouldn't go so the student rescheduled it. But when she got there she refused and the doctor wouldn't even do the breast exam because without the Pap smear it wouldn't mean anything. So she got nothing. And she is very psychotic now and is refusing a therapeutic dose of medication and I think that is part of why she is not compliant with the diabetes and the Gyn stuff because she is too paranoid. It just drives me crazy. She is another person I have put a lot of time and effort into, and I don't get the reward and satisfaction of seeing her improve. She is just sick and crazy. And when I arranged a visit with the diabetic doctor she didn't want me in the room because I am not a doctor and I don't know anything about diabetes and I don't know what I'm talking about even though I say the same things as a doctor. Just the fact that I have been trying so hard and she threw me out. Then I set up these appointments and begged the student to go with her and the student had to ask permission to miss her group and twice the client got to the hospital and refused. So I'm fed up. I'm really out of options. I am just done. So maybe if they hospitalize her for psychiatric reasons they will be able to stabilize her medically. But I'm not doing any more of what I did. I've done everything I can do.

This attitude was echoed in the following remarks describing an incident involving a diabetic client:

> Just today, I had a person who is diabetic that just got out of the hospital. He was in there for nearly a month and I find out I am being betrayed with cookies! And I am saying, "If I could only take these cookies away from him." But I can't.
>
> I saw him a block away... and I wear glasses and I can't see that well! And I saw him eating cookies. I said, "What are you doing?" He was in shock and he smiled a bit. I said, "This is serious. You have to think about what can happen to you." He said, "Well, it only has x amount of grams."
>
> ...Some of them get it and some of them don't, and some of them get it only for the moment when you're standing in their face.

The use of the word "betrayal" seems to indicate how personally this worker took the client's noncompliance. Not only is the client harming himself, but he is also defeating this staff member's extraordinary efforts to save him.

Feelings of Helplessness

Feelings of helplessness created by their clients' noncompliant behavior were often palpable in various comments. For instance a case manager noted that

> it is out of the professional's hands. The professional can't rope him in and make him change his diet for instance. You are just there and you become ineffective-just try to talk to them-not much you can do. We can suggest but it is not our place to say no.

Another person's remarks also underscore the helplessness staff feel in the face of clients' noncompliant behavior:

> But then there is the issue of poor judgment. And you can watch somebody go downhill because their judgment is poor. And you know you can't really do very much about it. It's a kind of awful thing to watch.

Additionally uncooperative behavior could be dangerous and therefore alarming to the staff because of the severe consequences of such behavior. For example:

> You can't force people to take their psychotropic medicine either. But you don't feel as ineffective because we have some sort of 'tool' if you will. When they are not complying with psychotropic medication regimens they could be hospitalized because of decompensation. But a couple of clients have no insight into their diabetic conditions. If they don't take their meds they might die.
>
> It's not that I feel different about the noncompliance but I do feel more can be done when there is noncompliance with the psychotropic meds. We have a protocol for that. We have a plan for that; we know what to do. If he eats ice cream, we just wait.

Self-Determination as a Moral Dilemma

The staff in one team described themselves struggling with a "moral dilemma" when they are unable to control their clients' noncompliant behavior. The following discussion about clients' eating behaviors and " a certain amount of self-determination" conveys the difficulty:

> Worker 1: We are not a hospital where we can give them a tray. We give them their money and then they go out and buy donuts and whatever else they want. We don't have control. I don't know if we should have control.
>
> Worker 2: My understanding is that the residence is supervised but it's not a dictatorship. We can only do so much and it would be horrible to put in a regime.
>
> Worker 3: I have a question. If people go into a hospital, they know this is what you are going to be dealing with. Well I don't know if it's an expectation. But the doctor can write an order saying no salt diet.

In the face of such noncompliance, staff members may be hard put to remember that these patients are mentally ill, and that their lack of judgment and self-destructive tendencies are not manifestations of any desire to frustrate the staff, but are instead symptoms of their illness. One staff member acknowledged that it is sometimes "very hard to be objective, very hard to take into account that he is mentally ill, that he does have poor insight, that he is symptomatic, and that he is not at fault for how he is behaving." In fact, staff acknowledged feeling angry at times with clients. For example,

> When they want to challenge you because of your age or something like that. You're telling them to take their medicine and then they look at you like, 'Oh you're too young. How can you tell me something like that? I'm old enough to be your parent. Where did you go to medical school'. And they start challenging you. That's what starts getting you pissed off.

> You're here to do your job, you know, what you're supposed to do, you know, the best referrals or references. But then they will be challenging you, giving you a hard time to do your own job, that you're just fighting with them, verbally that is. But that's how you feel sometimes. It's like, Damn, I'm trying to help this person and they are stressing me out. You do your job, you continue, you get them what they need to get. Put them on their feet. But then you go home and find yourself saying to yourself: This damn guy or gal....

Guilt and Anger

In turn, respondents made several remarks indicating that they often feel guilty about their anger toward clients who are noncompliant. Many staff thought they should be able to recognize that noncompliance and "rude" opposition to directions were a reflection of mental illness and that therefore they should not hold clients accountable. One assumes that therapists experience some guilt when they recognize their hostility toward particularly offensive clients, but this guilt is exacerbated when the disliked client is or becomes physically ill. A worker described how she redoubled her efforts in working with a very difficult character disordered client as follows:

> I think part of why I did so much for him is to compensate for not liking him. He was so abusive...to me...to other staff... and to clients. And he lied all the time.

The fact that this client had been extremely abusive clearly did not appear to allay the staff member's guilt. On the other hand, there were comments of workers who refused to feel guilty. One worker said it was a mistake to assume that bad behavior is always a product of mental illness and that mental illness can be a "mask for bad character." A supervisor pointed out that

> We have some very disturbed people in our client population. And difficult personalities that may not let you help. You're limited here in a certain way. You're limited by the extent to which the client makes himself or herself available to you. They don't keep their appointments. They do all kinds of foolish things. And, you know, you can't really do very much about it
>
> .
>
> So when things go wrong, you risk being held accountable for things that you really...that the client doesn't let happen. You may know in your heart that you've done pretty much the best and the right thing. But that doesn't necessarily mean that you've (really accomplished) everything, because the client (doesn't cooperate).

An ancillary stress related to the problems created by mental illness is the tendency of clients to blame staff when something goes wrong medically. For example:

> clients may become...angry, hostile, (and) volatile in situations where peoples' health is at risk and where there are unexpected things like medication reactions that nobody planned...and nobody did anything wrong. Or somebody goes to the hospital and something happens unexpectedly. That client may decide their case manager should have sent them earlier...or that their psychiatrist should have done something different...or that the agency was responsible. Now, maybe we weren't. Probably not. But there's a whole new strain, suddenly, on a case manager with clients like that.

Responsibility for Clients' Physical Health

It is one thing to attempt to help clients improve their mood and their sense of well-being as well as stabilize or improve their psychosocial functioning. It is quite another to attempt to save clients' lives. Nevertheless, the staff report feeling that this is their "mission" and gave several reasons why. For one thing, the staff are often the ones who "see the first signs, you know, the changes." Another staff member offered that as a professional, "I feel personally this is a client, so if I'm generally interested in this client I can't sit there and say 'I'm only here for the psychiatric part. So what if he doesn't monitor his glucose level today, that's not my job.' "

The stress created by this sense of responsibility is evident in many of the participants' remarks. A case manager explained that he had to be "more alert" because it was his "job to get his client to a doctor so that things don't get worse." Another staff member's comments conveyed the urgency she felt upon noticing that one of her clients had developed sores on his arm. The worker described her need to have the client examined by a doctor as "urgent," because, "God forbid, I don't know what it is."

Still another social worker explained the reason for his need to understand medical issues as follows:

> I think if you are more educated about the disease or the illness, the more you'll be able to help them. They may have heard different stories. They may not have the correct information. You may be able to help them clear up different problems.

The increased sense of responsibility for keeping clients well was also "very scary" for other workers who expressed concern about "jeopardizing" their clients' health if they failed to recognize a problem. The stress they feel is described by two workers as follows:

> In a way we feel responsible for his well-being and his health. We want to do everything we can to make sure that he stays alive...that he gets the treatment he needs, because you don't want anything to happen!
>
> I'm generally concerned about their welfare. So I'm feeling if their needs are not met like they are supposed to, then what's going to happen with these

> clients? So that's another reason why a lot of times I like to be with them when they're going to doctor appointments and stuff like that. It's so I can feel a little more secure in knowing how to treat them.

There was even a specific word to describe what staff feared might happen to a client if they (the staff) weren't "vigilant":

> Because you figure with the mental illness, whatever diagnosis they have, they're going to have that all their life and medication can always keep it controlled at certain times. I think I would be more prone to say: Did you take your medication for your heart? Rather than say: Did you take your Risperdol? I know that's what I do with one client that I have that had a liver transplant. I'm like: 'Take your liver medications, versus take your psychotropic'. So I think we do it a lot, in that what I feel when I do that is that if they decompensate, we could always send them to the hospital and stabilize them. Versus if they don't take that medication for that medical illness, they could just *flatline* right there. And I think that would be harder for us to cope. I think it's harder for us to cope with a *flatline* versus coping with just visiting the psych unit at a hospital.

In Loco Parentis

Because the overwhelming majority of the clients have no family members to assist them, "maybe 80 or 90 percent have been thrown away by their families who are fed up with them," staff members tend to assume total responsibility for their clients' care because "all they have is us to help them." In effect, the staff members assume the responsibility of parents with respect to their clients. The role was described by the team supervisor this way:

> Suddenly here we have people for whom we basically function *in loco parentis*, in many ways. We are really...you can call the people in this room case managers, but that's a fancy politically correct term for parental figures when it comes to having to decide, having to oversee, and have the judgment that our clients don't have.

This supervisor pointed out that workers experience great stress when they have to assume parental responsibility for managing the care of individuals who cannot possibly take care of themselves, in spite of the fact that their professional relationship with these individuals does not actually give them the legal authority of a parent. He also noted that it feels "virtually impossible" for the staff member to be sure that he is making the correct decisions for his clients, when "you don't even know in your own life if you are doing the right thing all the time."

Another example of how lack of family creates a "real strain" on staff when medical needs are involved was described by a social worker this way:

> I felt honored by the client's request to accompany him to the doctor to hear his diagnosis, but I also felt taken aback by the responsibility. So I tried for days to find family members for him, but I couldn't find his son in the Bronx. It was a big emotional thing and so I brought a colleague who was also close to him so it wouldn't all be on my shoulders.

Lack of Training Concerning Physical Illness

This strong sense of responsibility for and commitment to their clients' medical needs is not matched by any sense of confidence among the staff. There were several references to feeling ill-equipped and without the necessary training to provide adequate clinical care for their medically ill clients. A social worker observed that he did not think "anybody who is a non medical professional should be expected to understand the medical issues beyond the average, usual point that the average person understands it." Nevertheless, the worker indicated that he felt it was necessary for him to understand all the medical issues because ultimately he is responsible for "in some way or another best managing everything that is going on with this individual, including the client's medical treatment." The staff member's sense of responsibility had even led him to do extensive research "to find out about all these medical conditions and the interaction of all these medications." One worker, who felt "handicapped" by her lack of medical knowledge, explained how for her the difficulty was with:

> not knowing exactly...not being trained on what to look for, actually having to handle it, to be able to decipher whether its psychological or medical. I guess in a sense it's also personal with me because I never like to be put in the position of not knowing.
>
> So I think the reason why I kind of volunteer to go to a lot of clinic visits, especially when it has to do with the medications and stuff like that, is because when I'm sitting in a doctor's office, I always have a pad and pen. So I'm writing things. I'm asking questions. And what about these medications? And what are these for? in the hopes of maybe assessing a client better.

Another case manager observed that,

> right now I rely on the clients to educate me. I didn't know anything about diabetes when I came here. I have only been here for four months. I have clients who taught me. But it's not necessarily their place to teach me, and I might not get accurate information, so we need to have training. So if a client says my blood sugar today is 200...everyone might not know that's high. A lay person may not know that. So those things are important so you can also recognize them.

As indicated earlier, the stress of feeling responsible for keeping their clients healthy is further complicated by clients' psychiatric conditions. Presenting symptoms may be confusing and especially so for persons not trained for or familiar with physical illnesses. Staff members described having to be "more attuned" to their clients' complaints explaining that they had "to decipher" when physical and psychiatric symptoms "clash." This pressure to "be more careful" is conveyed in the following remarks:

> You have to be careful in the sense that the client is not only mentally ill. He is also physically ill. So if you are seeing symptoms you are always tying to identify whether or not its mental or medical. It's kind of difficult. For instance, a client today came to me who is also medically ill and said he doesn't feel well. So I have to really listen. I have to stop to see what's going on so I can decipher what it is. Whereas when it's a client that's just with psychiatric problems, if they say I don't feel good or whatever and I'm listening to them but I kind of know by knowing their diagnosis I know what to look for.

The extent to which the sense of responsibility coupled with inadequate training is stressful is strongly indicated by the following statement:

> And the death part. If the clients are not compliant with their psychotropic types of medications, we can usually get them to the emergency room or have them hospitalized. But in the case of medical issues, a person can die right there unexpectedly. And that's something that is irreversible!

Respondents made several remarks that indicated the lack of training also extends to knowledge about how to help clients cope with the emotional demands of their medical illnesses. Two staff members described their sense of clinical ineptness this way:

> I have a harder time personally helping the clients through it, I think, or helping them work through somebody else's illness. I think because it is hard for them, I'm sort of at a loss, almost, how to handle it.

> My experience is limited in dealing with the seriously medically ill. I keep trying to reassure them instead of asking people what they think. My immediate reactions are gut, they're emotional. I can empathize but I don't have a lot of knowledge.

Interference with Social Work Tasks

In addition to the stress created by staff's heightened sense of responsibility, the physical illnesses also created other frustrations for staff. The medical problems frequently preclude the possibility of doing the kind of work that they had trained and planned to do. In their study, Blankertz and Robinson (1997) pointed out that these professionals generally choose their careers because they want to help clients improve their lives. Instead, mental health staff are now being asked to preside over what is often a downward spiral of physical deterioration leading to increasing misery and ultimately, possibly, to death. One case manager expressed his frustration as follows:

> I'm not comfortable with the fact that says, well, we will do the best we can...that belief system that some things are going to happen, some people are just going to die, some people are not going to make it. It's a belief system that I don't particularly like coming into an agency. If I lost a client and someone comes to me and says it was going to happen, my belief is that I'm here for making sure that it doesn't happen. That's why I'm here. I'm not here because I just want a job.

From this statement it would appear that individuals who are motivated specifically to better clients' lives are particularly frustrated when not only are they unable to help the clients get better, but also, they are unable to prevent them from getting sicker and ultimately dying.

Furthermore, even if one disregards the fact that their illnesses lead many of these clients to suffer and die, their medical problems would still be frustrating to staff because the need to attend to medical problems prevents them from doing the work they would normally do with their clients. One staff member described the manner in which his work was changed so that he could no longer interact personally and professionally as follows:

> Just having coffee with (the clients) individually is kind of like not a prescribed medication. But it's so essential. But you know what? I don't see that happening. There are too many medical issues to take care of.

Conclusion

This chapter has focused on understanding the ways in which clients' mental illnesses influence and hamper their medical care which, in turn, places pressures on the professional staff who feel responsible for, but unequipped to, manage the problems stemming from the behaviors. The stresses identified by the staff represented a sizable portion of the content of all the focus groups.

Previous literature indicates that social workers demonstrate effective ways to handle the customary behaviors associated with chronic mental illness. However when those same behaviors hamper adequate medical care and threaten physical health, there is considerable stress on professionals who feel a heightened, even "parental," responsibility for their clients. Additionally, the work created by medical demands interferes with established work for which staff are trained.

The following chapter will look at the clients' physical illnesses from the perspective of the emotional impact on professional mental health staff.

Chapter V

The Impact of Clients' Physical Illness on Social Workers' Sense of Personal and Professional Vulnerability

Introduction

It is safe to assume that a sizable number of chronically mentally ill individuals residing in community mental health settings now have co-occurring physical illnesses, many of them potentially life threatening or already diagnosed as terminal. This project sought to understand how this inherently stressful reality impacted on the mental health professionals working with this population as well as on their practice. In addition to defining the substance of this occupational experience, the project sought to understand both how the professionals negotiate these new demands.

This chapter will describe how the clients' physical illnesses affected the professional staff, particularly in terms of the impact on their feelings of personal and professional vulnerability.

Review of the Literature

There is literature which suggests that the experience of working with mentally ill clients who are also physically ill could potentially be problematic for the mental health of the professionals working with these clients.

Two studies looked at the experience and consequent competence and sense of effectiveness of social work graduate students. This is a population which closely resembles the current participants in that both groups have not worked extensively if at all with seriously physically ill people. Both, therefore, lack the requisite knowledge and skills for competent practice in this area, factors which have been found to moderate aspects of burnout.

A "quantitative-descriptive" study of the fieldwork experiences of second-year social work students in oncology settings, (Weitzman and Beder, 2000), represents a quantitative effort to develop knowledge about the nature of social work with cancer patients. The study, which aimed at strengthening the fieldwork supervision for students, supports the impression of earlier authors regarding the stresses in healthcare social work. In its findings, the field placement was described as "intense, stressful, and emotional" and physical illness and patient deaths were the two "most difficult and demanding factors" of the students' experience.

Likewise, in their correlational study of levels of social worker competency, burnout and job satisfaction, Himle and Jayaratne (1990) found that undergraduate social workers were more burned out and had less job satisfaction than their graduate level counterparts. In training and competency, the former group most closely approximated participants in the present study.

A third related study looked at the practice preferences of a group of social workers in graduate school. In this examination of the interests of graduate school trainees, O'Hare (1997) found that "a significant core of social work graduate students" were considering a career working *chiefly* (investigator's italics) with seriously mentally ill persons, (p. 241). Another study, of psychosocial rehabilitation workers, found that 64 percent were motivated by a "desire to help people with *severe mental disabilities*" (investigator's italics) (L. Blankertz and S.E. Robinson, 1997, p. 226). These studies suggest the possibility that for many of the staff at Vistas, working with mentally ill clients is a specific choice and that working with clients who are also physically ill is unanticipated, and may even be unwelcome.

At present, however, the social work literature has not discussed this occupational stress of co-occurring physical illness in the mentally ill and it's effect on mental health professionals. There is, however, literature that seeks to understand the stresses of serious physical illness on healthcare and gerontological social workers. While keeping in mind Jayaratne and Chess's (1984) caution that the ability of clients to represent significant sources of stress may vary from setting to setting, this literature does offer a framework for looking at the stresses that the study's participants are now experiencing. Furthermore, Donovan's (1987) remarks support the notion that working with physically ill and dying people may be stressful for social workers regardless of setting. Writing about work site stress, she points out that "widespread perceptions of stress derive from objectively stressful conditions" (p. 262) such as serious physical illness.

Although much of the healthcare literature is not quantitatively based, Davidson strongly stated that there is sufficient qualitative evidence to support the notion that social workers in health care "experience strong affective reactions" (1983, p. 9) when working with seriously ill clients. She is referring to the extensive literature that descriptively catalogues the stress factors inherent in working in healthcare. Included in this anecdotal inventory are patient characteristics (Davidson, 1985), the "dreaded sights, smells, and sounds" of physically ill patients along with powerful fears of death (Pilseker, 1979, p. 370), feelings of professional incompetence and failure, Mailick (1991), and over identification with patients, especially when there has been a personal history of illness (Koocher, 1979).

In a quantitative study, Diaz and Mattison, (1992), considered the factors that influence oncology social workers' careers and "survival." Their survey employed variables identified in the literature on coping and burnout in order to establish the stresses. They found that history of personal loss, organizational factors, patient-related factors, and social support were major predictors of worker adjustment. Moreover, within the category of patient-related factors, the survey revealed that the most stressful factors were the intense contacts with patients who die and/or are suffering followed by identification with these patients' plight as well as feeling inadequate to meet patients' needs (p.117).

Similarly, there is literature concerning the emotional stresses on gerontological social workers that also has applicability for understanding the experience of participants in the current study. In looking at the countertransferential reactions of these professionals, Greene (1986) found that they had higher levels of death anxiety than did other social workers. Carrilio and Eisenberg (1984) see this reaction as due to the fact that social work with the elderly "requires confronting loss, declining health and death" thus reminding the workers of the inevitability of illness and mortality. Comparable reactions emerged from focus group interviews with Vistas' staff.

Impact of Physical Illness and Death on Staff

Despite the absence of literature directly on this subject, the present study documents the ways in which mental health professionals experience intense emotional reactions to their mentally ill clients' physical illness, dying, and death, as well as their feelings of helplessness in the face of clients' physical suffering.

The staff's disturbing feelings and concerns regarding the impact of physical illness fall into three areas which mirror findings in the current medical healthcare literature, namely: exposure to the "shocking," "horrible" characteristics of clients' physical conditions and deaths that can be "torturous" for staff to observe, identification with their medically ill clients that activates concerns for their own health and fears about their own mortality, and generalized feelings of helplessness and guilt.

This chapter will discuss the stressful factors associated with clients' medical conditions and provide examples from the content of the focus groups.

Exposure to Physical Symptoms, Suffering, and Death

Discussions in the focus groups were replete with examples that conveyed how emotionally vulnerable staff feel in the face of their mentally ill clients' medical illnesses. These illnesses could involve either acute symptoms or lingering decay.

Exposure to Chronic Physical Illness

Beyond the problems of psychiatric illness, intense involvement with medical illness means being exposed to unpleasant, even appalling, physical symptoms as well as pain and suffering. Numerous comments by staff conveyed how unnerved they were by what they saw. A residential case manager described how "scared" he felt seeing a client with advanced emphysema as follows:

> When he tries to breathe he can't get enough air and the way he has his mouth open, you know, it ain't pretty to look at.

Similarly, a worker in a day treatment team explained that exposure to clients' horrible physical illnesses meant

> watching someone living in pain and with progressive diseases. That is terrible for me to look at.

Talking about her difficulties with the situation of a young woman with a terminal cancer, a staff member explained her reactions this way:

> I feared all the pain and suffering for her. It was also torture for me. I have seen a lot of that pain and suffering and torment here and it is real scary for me.

For another worker, "the process of a client's suffering was depressing" and "the quality of life becomes the thing that is hard for me to face and deal with."

Other remarks described equally disturbing situations which infer the emotional impact of clients' chronic medical illnesses. For example, a day treatment social worker described working with a client "for almost two years" who has now been diagnosed with terminal cancer that can no longer be treated. The fact that she would now be faced with issues of dying were clearly inferred by this worker's discussion of her new concerns about what she might "have to handle now."

The stress of watching a client gradually deteriorate physically was evident in the remarks of still another staff person speaking about her reactions to a medically ill, residential client's continuous hospitalizations:

> Yeah, because they've been here for a while, then they left, then they came back. And it seemed like they never got back to how they were before they went in the first time. And we all kind of sort of expected it, but it still was, even like the medical staff here was figuring: Oh, they've probably got another couple more hospital runs to do before this actually happened. And then, when this happened, then it was a surprise. To me it was a surprise.

Exposure to Acute Episodes of Physical Illness

A case manager in one of the residences related a chaotic incident that graphically illustrated how "disturbing" clients' acute physical symptoms and illnesses were for her. She described how she discovered

> ...one of my clients was lying on the floor and he had blood clots coming out of his nose...I rang the bell for one of the staff counselors that was on duty. She called an ambulance...the counselor escorted the client to the hospital, and then I got a call that he went into cardiac arrest on the way to the hospital. ...he was at death's door...that wasn't expected. That was very shocking...I'm trying to pick up blood clots with paper towels and the (other) clients were yelling at me...it was just a horrible, horrible thing.

Coping With Client Deaths

In addition to trying to cope with the impact of clients' numerous physical illnesses and symptoms, staff are also regularly faced with death. The following remarks indicate just how stressful this is for the participants in this study.

A worker talked about his shock at finding a client dead in his apartment. The incident was so disturbing to him that for several weeks he was unable to be alone in the office for fear of "seeing something." The same worker also described another incident that suggests how alarming it is to be confronted by the reality that death can happen so rapidly:

> We had another client at ___ House. She had developed a fever and she had cold-like symptoms. We gave her soup. She took aspirin for the fever, but the fever didn't break. So the next day we took her to the hospital. And they found out that she had chronic leukemia and she died the next day. She was about 26 years old. So that was very surprising. She was very heavy set. She didn't look physically ill. She didn't have any symptoms other than those cold-like symptoms. And then she just died.

The emotional impact of client deaths on the staff could be long lasting as well as sudden. The following remarks indicate that the deaths of two of his clients had a profound and lingering effect on this staff person. Paraphrasing slightly, he said:

> Gary died...I actually found him dead in his room one morning...and there was Therez.... They died within six months of each other.... I never thought that I would ever think about them again...but you don't forget them. Every so often if I sit at the house meeting I will suddenly think of them.... I think of them from time to time and wish they were there.... Over half of the house are medically ill...diabetes, cancer, hypertension, obesity, brain tumors.... You know, when I originally came here I hadn't thought about this.

Furthermore, the worker suggests that he was not prepared for this aspect of the work when he came to the agency. His sad observation that he had "come to recognize" that "nobody is born in this agency" seems to infer an uncomfortable realization about the reality of client deaths.

Coping With the Aftermath of Client Death

Seemingly mundane tasks could have emotional ramifications long after a client had died. These could range from collecting a client's mail or contacting family members to

> having to go up to the room after the fact. Even though it didn't happen in the room, but just going up there. That was like the first time I've been up there since I found him.

Even staff who had previously worked with clients with serious physical illnesses reported being stressed by exposure to the deaths of their psychiatric clients. A case manager who had worked with chronically ill and dying AIDS patients explained it this way:

> it's a horrible experience if you are not prepared and don't expect it. I worked with dying people and you put yourself in a frame of mind or have a certain philosophy about things. When you expect it, it's

> different. Somehow it's different when I worked with people who are always dying.

The comments of this worker, who had chosen to leave her previous job to work with psychiatric clients, indicate how coping defenses are activated in different settings. Her remarks that once out of a medical setting, she was no longer "prepared" for death, i.e., as defended against the realities of death, provide insight into why the mental health staff were so unprepared for what happened to their medically ill clients.

Identification With Physically Ill Clients

Identification is an unconscious process in which a person sees features in another individual or that individual's circumstances which are similar to one's own qualities or situation. The participants in this study gave many examples of this process and the disturbing affects stirred up.

Confronting Mortality

One staff member's comments indicate how identification functions. In talking about why she left a hospital position to work in a psychiatric setting, she explained that now she would be able "to distance myself more. I don't feel I am in danger of becoming mentally ill but anyone can get other physical stuff. You never know." However, when she began working at Vista where she had clients with co-occurring medical illnesses she no longer felt this "safety" explaining that "it's got to...your own mortality...Heck, you know."

Identification with medically ill clients and the concerns about mortality that this stirs up were clearly evident in several other comments as well. For instance, a day treatment social worker pointed out that working with clients who develop physical illnesses is

> ..challenging to my own mortality. Actually, I went for a physical this morning. I usually cancel them. But, "No," I said...and I reflected on how a year ago K. (refers to a client who was at the hospital near death at the time of the focus group) went to the doctor and had a high PSA and there was really no follow up...Then a friend of mine went for a routine physical and they found something. Just a plain old routine. So those two things really got me going.

These feelings resonate in the remarks of a staff member who was working with a client currently hospitalized with advanced cancer. She explained how the client's terminal illness "starts me getting into my feelings about death and dying and being an old lady, stuff I don't want to think about." Another person pointed out that "when it's an older person, you can at least see it coming. But when it's someone young, you'll be like: " 'That could be me kind of thing.' "

Existential Concerns

Furthermore, client deaths can activate significant, often troubling, existential questioning about the meaning of life. For example, a young case worker said that recently he had lost two of his favorite clients. In pondering their deaths, he asked, "Like, why do bad things happen to good people?" He indicated that this question had become "a major thing for me."

Similar concerns were haltingly voiced by the supervisor in one of the day treatment teams as follows:

> I never, it's life, death, very much and I never wanted it to-- and as a little kid, you know, I always had to accept it and I always felt like there is nothing you can do. I would try to come up with these beautiful... you know, like, I'll see you in heaven, maybe you'll look down on me who knows, maybe you are in a better place... whatever. I still have not read that book When Bad Things Happen to Good People, but I have never accepted that it has to be. But here it is and I am struggling with that.

In speaking about a young woman who had entered the agency after years on the streets and in an encampment, a case manager's remarks convey her efforts to grapple with existential issues. For her, "It is a very bizarre kind of thing to see somebody physically and psychologically kind of blossoming and also knowing they are going to die. It just doesn't make sense."

Concerns About Personal Health

Observing the progress of clients' serious physical illnesses and ultimately witnessing the deaths of some of these clients also engenders concerns about staff's own health. According to one worker,

> Every so often I reassess. I come from a family where males don't survive beyond age 45...diabetes, high blood pressure, cancer...you name it. And I don't have a thing. So for me to break that cycle

> means a whole lot. Working here reminds me of illnesses too much. It also concerns me.

Another worker was concerned that the stress he experienced in dealing with his clients' medical problems could potentially effect his own health. He remarked that "what happens here is an accumulation of emotions and stress factors that can contribute to the (deterioration of) our own physical health."

There are also concerns about more direct risks to their own health. For example, a residential case manager described an incident where a client with HIV had scrapped his elbow which began to bleed "very profusely." The worker said that she felt "it had to be addressed even though there were no rubber gloves available." While she washed and bandaged the wound, she saw people who looked "very squeamish and uptight" but as a professional she believes "you just do what has to be done and every one of us has to be prepared to do that."

Feelings of Helplessness and Guilt

Feeling helpless in the face of so much suffering was evident in the remarks of a staff person who described feeling overwhelmed at seeing a client's misery. "It was torture, a horrendous thing to see a young man in so much pain and not be able to help him."

A case manager spoke about how he felt better equipped to deal with the clients' psychiatric illnesses because he had considerable training and experience. He then emphasized how he "feels much more helpless in the face of physical ailments because I am not trained."

Avoidance as a Response to Helplessness

Because clients' physical illnesses are so emotionally unsettling to many of the staff and also often leave them feeling "powerless to help with the realities of dying," there were several remarks about wanting "it to be over" or hoping not to be there when the death occurred, or not wanting to be the one to find a client dead in his room as had happened in at least three residences.

Several staff commented they felt "guilt" for having such "unprofessional" thoughts towards their clients. Following a meeting of the Pilot group, the manager of one of the residences brought in a cartoon from The New Yorker. In it several men were standing at the door of a hospital room talking to a woman. The caption read, "Sorry Sylvia, but your mother's long term care has been going on too long." The worker's comment that "here's a cartoon for the group" seemed to be an allusion to previous remarks of wanting clients to die about which the staff feel guilty.

Second-Guessing Prior Decisions

Staff members described frequently second-guessing themselves and their efforts when a client dies, asking whether they had done everything or enough to save the client. The supervisor of the Scattered Site and Graduate Housing CDT team noted that he often sat in on the review meetings that are held routinely following the death of a client due to a medical illness. He suggested that he had a somewhat objective perspective, due to the fact that he was not an active participant in many of these cases. He said that what he observed in these meetings was "always very sad." He said that "the case managers and the therapists and the people who work with them really, really suffer." He indicated that as an objective observer, generally he could see that:

> there was probably nothing that anybody could have done...or that people did everything they possibly could have. But then the case manager wants to know, "Did I do everything I should have done?" People have kind of tormenting feelings that they have to work out for themselves.

The supervisor seems to be suggesting that the staff members who work directly with the clients are not able to step back and gain an objective perspective which would allow them to acknowledge that they had done all that they could do, that there was nothing which could have been done to save the client. The staff appear personally too close to the clients to be objective about their own efforts to help. This may well leave staff members vulnerable to feelings of guilt which may threaten their sense of competence as professionals and ultimately their own psychological well-being.

Avoiding Work With the Physically Ill

The study also found that many of the participants who gave reasons for specifically choosing work in mental health explicitly indicated that avoiding work with physical illness and death was a primary motivation. The following statements are illustrative. A social worker who left a hospital setting explained that "blood and gore were too disturbing and depressing." Another worker's choice to avoid working in a medical setting hinged on the fact that there was just "too much loss. I didn't like what I saw. The fact that you work with people who are medically ill and the consequences of it is eventually death." A staff person who had worked in a nursing home for eight years before coming to Vistas explained that she left because she "wanted out" of the constant exposure to grief. "Over there was a lot of grieving, death issues, people crying all the time." As one respondent put it, observing clients' physical conditions and deaths stirs up "a morass of feelings and concerns." Another described it as "almost free floating anxiety. It sort of hatches a lot of concerns that people have right under the surface."

These vague feelings of discomfort can emerge at unexpected times. For instance, a supervisor described a "kind of total, spontaneous, undefended feeling" which she experienced as highly stressful. She said:

> ...It doesn't happen like, "Okay, now. This is it. Now the feeling." It comes for me at least intermittently. Unexpectedly, all of a sudden something will bring it back. Some people say something. Another client will talk about

> someone who's gone...maybe a year later. You don't know. So you never know when you're going to have the feeling.

Conclusion

This chapter has focused on understanding the ways in which professional mental health staff experience and regard their clients' physical conditions. The stresses identified by the staff represented an important component communicated by all the focus groups and were consistent with what has been reported in health social work literature. These include strong, affective reactions to physical symptoms, suffering and death, disturbing identifications with the nightmarish circumstances of medically ill clients, and feelings of helplessness in the face of all the pain the professionals are unable to mitigate.

The following chapter will look at this occupational stress from the vantage point of its impact on professional performance.

Chapter VI

The Impact of Clients' Physical Illness on Burnout and Job Satisfaction

Introduction

One of the primary goals of this study was to identify the nature of the occupational stress mental health professionals are encountering as a result of the co-occurring physical illnesses and deaths of their mentally ill clients. The previous chapters focused on the characteristics and sources of stress that the staff experience, specifically the ways in which the interplay between the clients' chronic mental illnesses and their medical conditions affect the staff's work and the emotional impact of clients' physical illnesses on staff members. This chapter examines the occupational stress from the vantage point of its impact on professional performance. The constructs of burnout and job satisfaction are the lenses used to understand the consequences of working under these stresses. This chapter will discuss staff's experiences of burnout, job dissatisfaction, and professional fulfillment using examples from focus group comments to illustrate these concepts.

Review of The Literature

Because of the nature of their relationships with clients, the problems they handle, and the settings in which they work, the job related stress that social workers experience has received considerable attention over the years. A range of stress-related practice areas have been examined. Although not studied quantitatively, the earliest professional settings looked at were in child welfare (Freudenberger, 1974, Daley, 1979 and Harrison,1980). More rigorous studies of practitioners in other settings and roles and with other populations have followed including administrators, (Jayaratne and Chess, 1983), health care workers (Sieffert, Jayaratne, and Chess, 1984 and 1991), social work with the chronically mentally ill (Acker, 1999), and military family practitioners (Harrington, Bean, Pintello, and Matthews, 2001). There have also been correlational studies comparing levels of stress in various groups: male vs. female social workers (Jayaratne, Tripodi, and Chess, 1983), medical vs. family service workers (Bargal and Gutterman, 1997) and graduate vs. undergraduate social workers (Himle and Jayaratne, 1990).

Initially, the occupational stress of these human service professionals was explained in terms of burnout, "a complex of attitudinal and behavioral symptoms that are interpreted as indicators of dysfunctional job performance" (Gilbar, 1998, p. 39). This concept, which is considered the end product of extreme stress, holds that because social work is a client centered profession and there are intense interpersonal relationships between providers and recipients, there is a greater likelihood of frustration and fatigue, both physical and emotional. These feelings can in turn lead to "a syndrome of physical and emotional exhaustion, involving the development of a negative self-concept or decreased feelings of personal accomplishment, negative job attitudes, and a loss of concern and feeling for clients" (Pines and Maslach, 1978). Later, Maslach and Jackson (1981) labeled this lack of feeling for clients "depersonalization." Of these three components, "emotional exhaustion is the condition most commonly associated with burnout" as well as the "most widely accepted and recognized aspect" (Poulin and Walter, 1993, p. 5).

Burnout is also thought to be a multidimensional phenomenon. While "the major cause of burnout has been attributed to the emotionally demanding interpersonal relationships of professional caregivers with their clients" (Acker, 1999, p. 112), a key factor in social work jobs, there are other components as well. Traditionally these fall into three categories: personal characteristics such as history of loss (Diaz and Mattison,1992), client related characteristics such as chronic and complex problems (Beck, 1987) or life threatening illnesses (Stav, et al., 1986) and organizational factors including high job stress (Ratliffe, 1988) and job autonomy (Arches, 1991).

As noted in an earlier chapter, the concept of burnout suffers from a lack of both definitional and conceptual clarity that has made it hard to generalize findings from different studies or from anecdotal accounts. This may be why quantitative efforts to measure burnout either "borrow heavily from existing measures of job satisfaction" (Gilbar, 1998, p. 40) or use the Maslach Burnout Inventory (Maslach and Johnson, 1981) to measure burnout coupled with more recent measures considered under the rubric of job satisfaction (Penn, Romano, and Foat, 1988, Siefert, Jayaratne, and Chess,1991) and/or personal and client factors, (Poulin and Walter, 1993).

Job satisfaction has been defined as "a positive emotional state resulting from the appraisal of one's job situation and is linked with the characteristics and demands of one's work" (Aker, 1999, p. 112). In some earlier studies, job satisfaction was measured by the single, subjective question, "All things considered, how satisfied are you with your job?" (Barber, 1986) As work conditions in human services have become more stressful with growing concerns about occupational hazards such as increased social needs and declining resources, job satisfaction is now studied as a multidimensional construct. The generally acknowledged stress variables have been role ambiguity, role conflict, and workload. Over the years, numerous other factors have been added. These include challenging work, organizational resources, lack of recognition in the form of financial rewards and/or promotional opportunities, the quality of supervisory support, and the nature of colleagial relationships.

Bargal and Gutterman's (1997) literature review of the vast array of studies on the topic of job satisfaction offers a good picture of how comprehensive the list of potential burnout variables has become. These authors suggest that the varying correlations for stress and for moderators of stress that have been identified are at times confusing and even contradictory. Nevertheless, an array of studies underscores pressing concerns in social work about job commitment and retention (Mailick, 1991,Vinokur-Kaplan, Jayaretne, and Chess, 1994) that are an outgrowth of occupational stress, burnout, and job satisfaction.

Accordingly, in their study of the relationship between job satisfaction and burnout, Penn, Romano, and Foat (1988) noted that there has been some controversy about whether burnout should be folded into a broader model of occupational stress. Within the social work literature, there are studies attempting to identify the stresses on social workers in oncology and other health care settings which do borrow from occupational research (Supple-Diaz and Mattison,1992, Taylor-Brown, et al.,1982). These authors have developed various paradigms with an interactive perspective on work site stress in order to include an evaluation of personal, interpersonal, and organizational stressors. In so doing, the authors have emphasized the interactional nature of stress which makes the experience of it unique to the individual.

By contrast, Maslach and Jackson (1981) contended that burnout is a separate construct because of the particular stress stemming from the nature of the intense interpersonal relationship between providers and recipients.

The Impact of Clients' Physical Illnesses On Burnout and Job Satisfaction

The present study suggests that the staff at Vistas had their share of burnout and job dissatisfaction. This should not be surprising. The mental illness of their client population and the staff's long term and intense involvement with them have both been cited in the literature as factors which contribute to burned out human service professionals (Aker, 1999). The addition of the clients' serious physical illnesses, another recognized predictor for burn out, compounds the problems for this staff. Similarly, the stress workers described as a result of organizational conditions as well as increased workloads have been shown to contribute to job dissatisfaction (Jayaratne, S., 1993).

However, while the focus group discussions included many comments about worker exhaustion and feelings of professional futility, there were also numerous comments reflecting satisfactions the workers derive from their work with this population of clients. Also, it appears that these satisfactions equal or at least offset the stress related problems that were identified.

Burnout

Exhaustion, emotional withdrawal and a sense of professional inadequacy were all identified by participants as they discussed their work with their physically ill clients. Of the three components of burnout, ongoing exhaustion and a sense of futility were either mentioned directly in the group discussions or were inferred by the feelings described.

Feelings of Physical and Emotional Exhaustion

Weariness associated with burnout was often prompted by the clients' noncompliance with respect to their medical needs, particularly in the face of tremendous worker effort to help a client stay healthy. For example, one staff member stated:

> I put so much effort into D., this psychotic, diabetic woman with dysplasia and who knows what else. And I met with her doctor pretty much every two

> to three weeks. On Friday I had her go to the hospital because she had had a positive Pap smear last year and she never followed up. So this past Friday a student brought her to the hospital for follow up. The student called me saying D. wasn't going to do it. I said then tell her our doctor here is going to have to do it. D. said no you can't make me do it. I said you are right. And I put so much time and effort and documentation into this. Please, my documents with her are twice as long as anybody else's. (Sigh) I'm exhausted!

The level of concern for the medically ill clients also led to the kind of overwork that often leads to both physical and emotional exhaustion. "The clock never stopped" for one worker who found herself "constantly worrying" about someone when they were in the hospital. She described how she "carried treatment plans home and carried them in my dreams. It would keep me up at night." Another caseworker's activities on behalf of her clients seems equally fatiguing:

> I even take home the hospital phone numbers with me during the weekend just to check up on them. I feel they have no one. They don't have family visiting or family talking to the doctor. So we become their family.

These statements also reflect the ways in which the staff take on the parental roles and family responsibilities for their clients that were mentioned in an earlier chapter.

Another worker described the emotional exhaustion component of burnout very accurately without actually using the word, burnout:

> You can't work with a client for a number of years and get involved in their welfare, and it not affect you. If you're the kind of feeling person that I would think people in this room, you included, are, it just affects you, and you feel exhausted. It's difficult to say that it doesn't. And if anybody says it doesn't, I won't dispute them, but I find it hard...

Feelings of exhaustion were almost always precipitated by the "relentless" succession of serious illnesses and death of clients that created "almost continuous mental strain." For example, one worker said that to her it seemed "there was never an end" when she was discussing a client who had improved emotionally so that "now she was a part of us" but then had an abnormal mammogram which required a biopsy. In this instance, the concerns about the client having a potential cancer appear to compound the strain on this worker by portending new issues as well as undermining the progress the staff person felt she had accomplished with her client. Upon hearing that one of his clients had been diagnosed with a serious illness, another staff person said, "I found myself feeling, here we go again! That's exactly what it felt like."

Client deaths took an understandably large emotional toll on staff which over time could lead to burnout. This possibility is poignantly captured in the remarks of one worker who said he was "so tired" because he was "inundated" with death. He described how he had wondered about

> what it would feel like to get to know...when I first started...to get to know a client and watch them and have them die. It seems since I started there have been tens of clients (who have died) from illness and suicide and age and just whatever. It's such an exhausting...It's just a movie screen of faces rolling through my brain.

Another young worker graphically described his reaction to the death of yet another client this way: "It was like a bomb hitting an already bombed out building."

Feelings of Lack of Accomplishment

Feeling a lack of professional accomplishment was reflected in several staff members' perceptions that their efforts were like those of "a hamster on a treadmill, doing your work, doing your work, but never getting anywhere."

One worker expressed total frustration in her inability to achieve any meaningful change in her diabetic client's self-destructive eating behaviors:

> I have to talk to him. It feels so bad because you start to think, "Am I getting through to them? Do they understand? Do they care? Do I understand more than they do?" And it becomes a lie. Because you want them to and they don't.

Another worker expressed the sense of futility that overwhelmed her when she thought about the death of one of her clients. This worker indicated that she felt bad because she "wasn't able to do anything." Her sense of hopelessness was sufficient to keep her from sleeping, and she found herself "thinking obsessively of "all the other deaths" she had experienced during her life.

This worker's statements perhaps reflect unrealistic expectations about the limits of her professional abilities because she said that

> I can't always make a change and I can't stop what is going to happen to them medically. I can't save the world either which I thought I could by caring and I can't. It's a big realization and it is hard.

Nonetheless, the feeling is shared by other colleagues. While the objective was not always clearly spelled out, several staff spoke about their efforts to "make things better" for them, "protect them from pain and suffering and protect them from whatever is going to happen," in essence keep them from dying. One staff person stated that because she felt "burned out" she had gone to see a therapist, telling him that she was "really tired of taking care of people, of being the one who has to save the world. I'm really tired of it."

Supervisor Burn-Out

Supervisors also found themselves feeling burned-out and ineffectual in their roles with staff. The following remarks illustrate a supervisor's efforts and her sense that she was not very successful.

> And boy, I have a hard time. I was saying P., remember this. Like I tried to build her up. Don't forget this. But I feel so ineffectual as a supervisor to help her move on. I want to say, "Stop! It's not your fault. You did (all you could)."
>
> ...I feel bad about the client, but I also feel the responsibility in terms of the staff. I wish I knew how to take care of them, how to comfort them.

Emotional Withdrawal

Several workers also indicated that as a result of the exhaustion and repeated frustrations, they found themselves thinking of working differently with their clients. While the behaviors they described are more a conscious choice to be less empathic rather than a more subtle emotional depersonalization of their clients, the effect on their clients and the quality of the services they provide are the same. This stance was evident in the remarks of one worker who explained that:

> I basically took care of her. I mothered her. I got her home care, this care, that care, and what not. So (when she died) I swore I would never do it again.

Similarly, another worker noted that sometimes she did not ask about a client's physical condition, because

> I don't want to get involved anymore. It's the stress level, the stress level. And I can speak from a number of clients whom I have watched die...Just the idea of having to be there on a daily basis...It seemed to me more than I could bear because it's so hard.

A staff person who had worked closely with a client who had recently died stated emphatically that:

> I will never, ever let that happen again. I will do what I have to do for my job, but I will try to separate that from getting close to a client.

From these comments it would appear that staff members in this team had reached a point where they felt unable to relate meaningfully to new clients, because they were so burned out from the deaths of earlier clients. In general, one expects that for the social worker, getting close to and involved with the clients would constitute one of the most important aspects of their work. However, over time, and under the cumulative pressures faced by these workers due to the physical illnesses, suffering, and deaths of many clients, it appears that this equation is no longer certain.

Burnout was also associated with the intensity of the staffs' relationships with their clients. One staff person felt that staff often get "overly involved" with these clients. She pointed to a colleague whose emotional investment meant that "when they suffer she literally suffers and when they die, a little piece of her dies."

Effect On Staff Retention

While other staff did not explicitly use the word, "burnout," their comments highlight the concerns voiced in the literature about burnout leading to problems retaining staff. The following is an example of a worker's intent to leave as a result of the stresses of the work:

> I think there's a period, maybe once or twice a year, where I'm reassessing my role and my belief of where do I want to be as far as being in the environment of helping people. Do I want to stay in the mental health system? Do I want to go into the legal system? Am I going to be able to kind of live with these obstacles and frustrations over time, and be someone that can sit calmly, and the day goes by?

Similarly, another staff person stated emphatically that because the work had become so "taxing" and so "unpredictable" he "wanted out now!" This young man said he had gone back to school to study public administration so that he would not be working "one on one" any more. He was particularly concerned with how he found himself "taking home the wrong things." As an example, he described feeling irritable at work and was becoming short tempered at home also.

> You get stressed out and wind up taking it out on your family members and stuff. You go home to your spouse and start cursing or something because you're upset about something that happened with a client.

Job Satisfaction

As noted earlier, the literature on job satisfaction uses many variables for studying workers' experiences in their jobs. Initially the major predictors for stressful work were role ambiguity, role conflict, and role overload or workload. As conditions in the workplace have changed and become more stressful, the correlates for worksite stress have increased to encompass a wide range of problematic features in the workplace.

Many of the factors correlated with job discontent were discussed by the participants in the focus groups. They referred to being "spread too thin" and described themselves "running around like a chicken without a head" because there were so many tasks to get done for their medically ill clients. For example, a case manager who said he was "overwhelmed" by "pressures coming in at all angles" explained how:

> I may be concerned with client A's medical and psychiatric problems, and I want to get that all documented. Then client B comes in and has an array of problems that I have to deal with and write down. It just becomes overwhelming.

In a similar vein, another case manager's comments also indicate the sizable number of clients requiring the attention necessitated by medical needs. He related the following:

> When you have 16 to 18 clients and at least 8 of them have physical illnesses, it just gets overwhelming when there are two major dimensions, the mental and the physical. People get sick. You really can't help it, but then they have to take back in some other way.

The work problems that the staff identified fell into three categories. Participants noted that attending to the medical needs of the clients placed a great burden on their time making it impossible to accomplish the goals they had envisioned for themselves as mental health workers. Also, there were references to "the absolute horror of paperwork" that is required "to have things in order" for both internal and government mandated record keeping on the medically ill clients. Lastly, several staff spoke about "administrative nightmares" associated with the care of these clients.

Additional Demands On Workers' Time

Managing the additional, confounding and "time consuming" details of their clients' medical care was both frustrating and frequently unsettling. These details ran the gamut, from the problems of accompanying clients to medical clinic appointments to orchestrating the arrangement of follow up care, like

> making sure that you follow up with them when they get out of the hospital, or if they have something where you've got to link them up to home health and coordinating with the social worker at the hospital before they get discharged to come back.

The time consuming nature of some of the work is captured in the following remarks:

> When you have a client who is medically ill, it's time consuming. If they have a medical appointment you probably need to go with them and spend all day in the hospital. And you might have 12 other clients that you have to pay attention to and they might also have medical illnesses. Today you spend the day with one. Tomorrow you're spending the day with another. And you still have other clients that you have to help who might not have a medical illness.
>
> ...you're often interrupted in your daily routine. You have to take a client to a clinic appointment so that they get to the right place...sit all day with the client making sure that they get seen. So you spend all day doing that, and then there's follow-up. All of this takes away from your other duties and you fall behind. And that's a big, big problem, a frustration if you will, that I have. You fall behind not only in being able to keep up with your clients and their daily progress, but also with the paperwork...keeping the treatment plans and progress notes up to date. Because that is very important to do, especially around audit time. But if you're at a medical appointment with the client, you may not have a chance to chart it on that particular day. Nothing is like...Okay, now we're going to wait for you to suspend time so that you can get into it.

Client Finances and Funeral Arrangements

In addition to accompanying clients to medical appointments many staff described managing other time consuming needs of their medically ill clients' from finances to burial arrangements including "picking out the funeral home...something affordable...and something to wear."

A supervisor described having to manage the affairs of one of her elderly, medically ill clients as follows:

> There's no family. There was no legal document. There's no will. He's got a lot of money. He's got a home. I feel like taking care of him is a full-time job. I had to get him a lawyer to handle estate issues. He calls me all the time for help. I'm in contact with the social worker and the doctor at the hospital. The burden is all on my shoulders. But I feel it's my professional responsibility.

This manager clearly felt overwhelmed by the demands of this client. Yet just as clearly, she felt it was her professional duty to meet these demands. When one considers that this burden has arisen in connection with a single client, the potential for overload across staff members' entire caseloads can be enormous.

Another staff member described similar demands placed upon him by a client with cancer whose physical condition was deteriorating rapidly:

> And it spread even more. This was very, very, rapid. And there was no plan...There was no plan. And what happens? Make sure I'm going to get buried...Make sure of this, make sure of that.

In both instances, the staff members infer that they are in the unenviable position of being asked to perform a great many demanding and time consuming chores for clients who are dying. These tasks are more practical and mundane than they are professional. They may also be more emotionally disturbing for the workers given the circumstances they describe and the nature of the work. Yet these tasks reflect the needs of the clients at this time, and the staff members are hardly in a position to refuse to do them. Thus it would seem that from these examples, the staff members feel overburdened by the work they have to do on behalf of their medically ill clients and denied sufficient time to pursue other work objectives that might well be more rewarding or less frightening.

Increased Paperwork

In general, paperwork was a "real pain" for the participants. Along with client medical illness comes both an increase in the volume of documentation, since notations have to go in multiple records, as well as more complex treatment planning. For example:

> I may be concerned with client A's medical and psychiatric problems, and I want to get that all documented for the State. Then client B comes in and has an array of problems that I have to deal with and write down. It just becomes overwhelming!

The staff also described a heightened sense of responsibility about making sure the records were accurate and compliance issues. For example:

> Unlike a mental illness where a lot of people in the day program have a piece of what's going on with that individual, if that paperwork is not up to date medically, when someone goes to grab (it) and find out what's going on with this person medically, for instance when we are on vacation or are out sick, or we have a personal crisis that doesn't allow us to come into work, and that client has a medical situation where others need to access that information

> right away, and that will push you even more. Other people, the team leader, supervisor, or coworkers, have an understanding of what's going on with the person's mental illness. They do not have an in depth knowledge about what's going on medically. The source of that (information) would be the paperwork, the chart.

Administrative Implications and Workload

Periodically, medically ill clients could become "administrative nightmares." For instance, "scared" clients often behaved "horribly" at medical appointments so that as a "tradeoff," staff had to escort them. This meant that not only did some staff have to leave their work to be "picked up" by other colleagues, but also this arrangement was used frequently and became an "expensive" budget item in the form of taxi fare.

Another administrative nightmare was the level of time-consuming coordination required to ensure continuity of medical care for these clients. This was clearly illustrated in the case of one client, whose complicated situation was explained as follows:

> ...at one point she was at St. Luke's, she then was at Metropolitan. Who the hell was doing what? We had to get records from one place and give them to the other place. She was having an X-ray someplace else -just to coordinate all of this - because on occasion when we had to call on 911, wherever she ended up that's where she would be treated. It was a mess! A lot of phone calling and record sending. It was just really tough.

Lastly, there was the issue of "administrative responsibility." For example, the team leader described the urgency of accountability for these clients.

> God forbid she missed an appointment and something happened to her, that was on our heads. There would be somebody outside breathing down your neck, did you cross every T, you know, do everything you are supposed to

> do to cover yourself? And did you do what you're expected to do for them, that you are getting paid to do as a responsible clinician?

This woman expressed discomfort about the fact that she "really sort of sometimes sees people as a liability even though I don't want to." She then went on to justify this assault on her professional ethics. She explained:

> I know there is a part of me in risk management and believe me I want to take a risk management course because I need to feel a little more empowered about what I can do and not do and what is really expected of me. Because I don't want to get caught with my pants down.

The stress of the workload on this staff as well as their professionalism is perhaps conveyed best in the following remarks:

> You know how it is in the residence. You use any means possible to get the job done. Getting by and the work is getting done. Clients are properly taken care of, staff is getting paid, but the stress is beyond belief.

Bureaucratic and Organizational Obstacles

In addition to the problem created by stressful workloads, the literature on job satisfaction cites the potential for stress created by bureaucratic obstacles and organizational deficiencies. The participants in this study described a host of problems in this area including external pressures, a lack of agency concern or recognition of the difficult work they were doing, and inadequate interagency communication in the form of nonexistent procedures and staff shortages.

Governmental Agencies and Outside Medical Providers

One external source of stress is the requirement of overseeing governmental agencies for complete documentation of medical information. As one staff member made clear, this does not mean simply keeping the charts up to date. Sometimes it is difficult to obtain sufficient information to know what to put into the records:

> Today I and someone else saw the results of the physical exam that was sent here from a medical provider. It had about six words in the whole thing. Clearly the person is healthy, but it would be nice if we got a little bit of information, so that if something happened it would be in the chart. And why do I say that? Because I know if an auditor sees that, the auditor is going to say, "How could you not try again when you get this scanty piece of information?" And yesterday that scanty piece of information took the whole day to get.
>
> In the reality of the world that little bit of information is probably fine, because it's a healthy client. But when we have an audit, that piece of paper will not suffice in the chart. It won't. I know it, because it doesn't even say negative. Even "neg." would have been fine.

The foregoing paragraph is particularly noteworthy, because it makes clear that the staff member regarded the level of detail required for the charts to be unnecessary and excessive. While the staff member is clearly frustrated with the scant effort made by the medical provider in reporting on the client, the staff member is even more frustrated by the government rules which demand an excessive level of detail.

Referring more generally to what he perceived as the problems created by government, a young social worker lamented about "society doesn't want to take care of people anymore so the government is breaking down of all these institutions so that there are more people needing care in the community, increased caseloads, and strapped staff."

In addition to the the frustration associated with the demands of government for excessive detail in client records, staff members are frustrated by the difficulty associated with obtaining the required information from outside medical providers. One worker complained about the "red tape" as follows:

> ...I have a client whose medical records are at the hospital. He doesn't get any medical services here. So in order to get his medical information I have to go through a process with them. Well, I've been going through that process. I've sent the release forms. I've called there. I can't get the information. And you can't get up and go to the hospital. Where do you go? You go there, you run into a roadblock.

Agency Shortcomings

Staff were not only concerned with bureaucratic pressures from outside agencies. They also complained about problems arising from within the agency, including a lack of concern for the feelings and well-being of both staff and clients, poor interagency communication stemming from a lack of protocols, and staff shortages.

In discussing their feelings that the agency did not support them, several staff who felt alienated, "like being in the provinces or the frontier," said administration seemed both detached and unappreciative because "It goes in one ear and out the other." For example, there were the angry comments of a counselor who perceived agency higher-ups making decisions without enough knowledge of the realities of working with this client population or without input from the residential staff:

> Sometimes it seems detached, like okay, this is administrative and this is just a lowly counselor and technically we feel that after 4:00, after the paperwork

> is done and everyone is gone--but we are the ones that are really here to deal with the clients on a first hand basis.
>
> We're doing part of what they do administratively and also what we do. We have to keep it going technically. They will not make appointments, they will not be here for billing or anything else if it weren't for us.

Other staff who felt that the agency "doesn't necessarily have your back, is there for you" added that they needed some visible recognition from the administration. Unlike the findings in some job satisfaction literature that financial rewards were a consistent predictor of satisfaction, there was agreement by the participants in this study that the recognition from "the people higher up" didn't have to be monetary. Rather,

> I think they need to hear--the administration needs to come down here and say to the counselors 'you are doing a terrific job.' It's not necessarily financial. But come in, let them hear it. Give them some sort of token in terms of a little plaque or something saying thank you for a well done job.

Other workers complained that agency decisions indicated that the administration simply did not care enough about them or the clients. For example, one staff member complained bitterly about the decision to eliminate the agency gymnasium in order to provide more office space:

> This is a frustration that I have, because I love to be physically active, and I used to run the gym, and it broke my heart when they just said, "We need office space, because we need a caseload, because we need billable services, and so on and so forth. There were people that went. I would have had no problem taking on the project of finding new equipment, whatever. But seeing how things are being eliminated and shifted around...So if you talk about someone's health, and I know that there was talk last month or this month downstairs about how we are going to address diabetes and nutrition? Not one word was said about exercise.

Another worker complained that the agency had eliminated activities that staff felt were helpful in reducing their stress:

> They used to have a concept when I first started that they called retreats. They went from a weekend retreat or something and then they used to have an annual retreat where people would meet and talk about these stress factors. And now there isn't any outlet.

This latter observation is noteworthy in that while budgetary constraints brought about by changes in government policies and funding were largely responsible for the elimination of many services, nonetheless, the staff member appears to have implicitly attributed the elimination of the retreat to a lack of concern on the part of the agency for the well-being of its staff.

Staffing shortages due to funding constraints created coverage problems as the following comments illustrate:

> We sorely could use more staff because then we'd have more time, could spend more attention, be able to go into more detail with them. For instance, I have at the moment someone here who is here from 8 to 12. Now, they have to take people for appointments. At the same time, they have three clients to write notes for, to do ADL with. And they're only here for four hours in the day. And if one of those clients cannot do their ADL properly, and doesn't clean their bath properly, my problem is, how am I going to arrange for this client to get this attention?

Shortages also led to staff working overtime, "although we have to argue for over time because they don't like to pay it," sometimes giving up vacations, and frequently, as mentioned earlier, spending precious time accompanying clients to day long medical appointments because of the lack of ancillary staff to do this. Additionally, with the very limited night staff at the residences, clients regularly had to be sent unaccompanied in ambulances to emergency rooms which left staff feeling extremely guilty for "abandoning" them.

Problems of Communication and Collaboration

Communication was described as poor between different parts of the agency which at times resulted in painful let downs for staff and inadequate care of clients. For example, one case manager complained of her inability to keep track of a client as the young woman moved from one branch of the agency to the next:

> I was the original outreach worker who encountered her in the streets. Four years go by and you've finally got someone in. I had her when she was at the treatment center for rehab in Kingsborough. I took her to the hospital. I went and picked her up...And you spend all this time with her, and then all of a sudden it's kind of like...you work for the same agency, but now that she's sick and she's been transferred to the unit that follows the clients who have AIDS...you can't get any information. There's this disconnection without taking into account your relationship or your feelings... I'll get back to you when I can. And then all of a sudden, she's passed away. And then...because it stops becoming a human relationship, and it's more about...Well, now she's here, and the professional and this...and what you have to do is dah, dah, dah. And you forget the essence, the relationship you had. And then all of a sudden you walk in and you find out that she passed away, and you weren't there. Oh, God.

Another worker also felt that there was "poor collaboration between various divisions of the agency" and that this represented a larger problem, namely that internal policies were "not addressed." She felt this was because the "people on top (of the agency) are not the people who deal with things on a daily basis." Consequently procedures for things such as the timely sharing of medical information about clients' medical progress, protocols for medical emergencies, "medical alerts" in the residence offices on specific clients, and policies about confidentiality and "how to talk with medically ill clients" had not been considered or created. The problematic consequences that can occur as a result of the lack of clear guidelines was described by a worker's clinical example :

> There's a lot of confusion. Or even dealing with the client, because if the client isn't saying to me this is what's going on, then how can I say to this client I know this and this, you should do this and you should do that because of this. So the agency, the protocol, the procedures sometimes can make it scary also.

Satisfactions

Despite extensive quantitative research documenting the extent of social workers' burnout and the various correlates of burnout and job dissatisfaction, social workers also experience satisfactions in their work. In a study of a group of social workers in outpatient mental health settings, Aker (1999) found that while the work with chronically mentally ill clients had negative effects in terms of the correlation between degree of involvement and emotional exhaustion, overall, the workers were "relatively satisfied with their work," particularly in the area of personal accomplishment (p. 115-116). Sieffert et al.'s (1991) survey of a national sample of social workers in health care also found that while these workers had significant increases in their workloads over the ten years of the study (1979-1989), they also demonstrated a significant increase in feelings of personal accomplishment.

Most of the accomplishments cited by the participants are consistent with findings in the literature regarding what contributes to or constitutes satisfying work. For instance, there are numerous references to the satisfaction of helping clients, finding the work intellectually stimulating with regular learning of new information and the opportunities for problem solving that provided challenges. What stands out, however, are the ways many of the accomplishments, whether large or small, provide satisfactions for the staff in the face of situations that have the potential for eliciting overwhelming feelings of helplessness, despair, and failure.

Helping Clients Live Well and Die in Comfort

Helping people has always been a hallmark of the mental health professional. This belief was simply stated by a young man who had been in the army before going to graduate school. Although the work had its "ups and downs," he enjoyed the work "just for the fact that I'm helping people versus hurting people. It's just a complete turnaround. I enjoy it. I really like it."

But helping these particular clients who have co-existing physical illnesses involves more than helping them with their social functioning and activities of daily living. It also means helping clients cope with debilitating physical diseases or with dying. And even when faced with deaths, the staff found value in what they had been able to help a client achieve. The attitude was summed up by a "seasoned professional," who noted proudly that "any job worth doing has to take a toll."

The staff talked in general terms about the pride and pleasure they feel because of their role in helping a client "work the program and return to life" and their ability to give the clients "something they have missed." For instance, there was the client who was a "real mess" when he came to the agency but who was given "a home." And there are the clients from the encampment program "who used to be angry and suspicious and now have calmed down. We have changed their lives by showing them that we actually care. And this is more than they have had in a long time." Another person felt gratified that she was able to provide clients with "a nice place and staff who really do their job and want to make sure they're all right" especially since

> I always look at the fact that if you look in a lot of their histories, they were out there wherever they were for long periods of time surviving and doing what ever they had to do. We can make life a lot better for them.

Making life a lot better served as an especially invaluable source of satisfaction when clients became medically ill. Not only could the staff "give them something they had missed" but they could also feel helpful in the face of the kind of pain and suffering that would be more likely to foster feelings of powerlessness.

And there seemed to be many ways for the staff to be helpful. These included facilitating clients' visits to a peer, a young woman in the hospital. One of the workers explained it this way:

> It was my mission to get clients to visit C. in the hospital after the first week when everybody stops visiting her. So I kept reminding them, and since it was close enough walking distance I didn't feel I was asking too much. It was my daily announcement. I thought about her everyday. I think we all did. And we would ask each other if we had talked to her and what was happening.

Likewise, the team's administrator described how she arranged for agency vans to take clients to the hospital to visit and provided money for cab fare, flowers, and cards so that, "while everybody loved her but took it for granted, when she went to the hospital everybody could really show her."

Another staff person explained how she maintained contact with the client even when no one could visit in person. She described how, "We used to call her and just say 'Hi' and tell her we love her, that we can't get away right now but she was in our thoughts. Buying the young woman the jellybeans she asked for because it was her "death wish" assured another worker of her ability to respond in a helpful way to this dying client.

The fact that the hospital staff acknowledged both the staff and clients as "family" and "were very nice to us" provided another source of satisfaction as the staff helped this young woman. The hospital staff allowed them unlimited visiting hours and an unlimited number of visitors "when they knew her time was coming to an end." These gestures reassured the staff that their help was indeed valuable at a very stressful time for this client. One staff member remarked that the dying woman "felt and got a lot more caring than she did her whole life... especially during that last month."

After clients died, the staff often found solace in reflecting on the difference they had made in the clients' lives. For instance, in talking about a young woman who had died a few months before the focus group, staff described how they had helped her so that

> she was looking lovely, gaining weight, looking pretty, clearing up her skin, actually having a life with friends, and a social life, a place to live, to eat, a

> bathroom to go to. You know, friends that cared for her, that wouldn't use her, that she didn't have to sleep with for friendship.

The following comments capture the import of the staff's belief in their value to these dying clients:

> We can make life a lot more comfortable for people before they go. I've seen how you can really enhance what they have left. I've seen people who said they don't want to die a drug addict in the street. And we made it so they didn't die that way. I've seen that.

The staff also described the positive things they witnessed while working with their dying clients. They spoke of one young woman's "willingness to live" and her "refusal to give into her illness" as "amazing." A case manager remarked on how she was

> an inspiration to a lot of her peers and it helped them to cope with what was going on with her. You know, she wasn't ...you know...she was happy, she was clean and she let them know she was sick and that she was dealing with her illness.

Staff also indicated that they were greatly moved by the profound ways in which these mentally ill clients were able to relate to each. For instance, one worker described a client as follows:

> She knew she was loved. One of her best friends said the day before she died she was her soul mate, she was everything, her best friend, her confidant. She said if she could lay on top of her body and take some of the pain away or give her some of her health she would do it. And she had a lot of friends who felt the same way. They really loved her. And I think what was good about the whole thing was that they had time to terminate with her. You know, they had a lot of time to say goodbye, to talk.

There were also descriptions of experiences the staff had had with this young woman that seemed to be both personally and professionally moving and beneficial. This was clearly indicated in one staff person's remarks when she explained how she had learned to look at this client's behavior differently.

> I don't know, she kinda knew and we had the feeling she knew when she verbalized it. It was around the issue of the jewelry. She had like a major argument with me, in group and and everywhere else on the floor whereever people could hear it because she wanted to go out and buy jewelry. Whenever she got money she wanted to go out and spend it. She was very impulsive. Every minute she had to have something new. Usually we want people to learn to budget their money, to learn to be a little more thoughtful. But when she said to me 'I do not know how much time I have. I am probably going to die so I want my jewelry,' I had to really think about it, and then I said OK. That certainly made an impact, I know on me. and I had to really rethink everything.

There were also satisfactions related to helping clients deal with the emotional impact of the physical illnesses in ways that were less emotionally charged but no less important for both the clients and the professionals.

One case manager explained how she helped her clients' cope with their grief after the death of a peer:

> We are like receptacles of their feelings, especially the undenied feelings. And we have to manage those and help the client. And if they recognize that you are allowing yourself to grieve instead of bottling those feelings up and making ourselves sick with them, because bottled up feelings are part of their illness... so we can show them that it's all right to have feelings. That can be very helpful to them.

Explaining medical issues to clients and thus reducing the tendency of the clients to act out or become verbally abusive during their clinic visits was also an important task.

Another staff member indicated that he derived satisfaction from being able to help clients do simple things that they were unable to do but wanted to. For instance, this staff member brought a card from a client to another client who was in the hospital. While this may seem to be a small thing, it was extremely important to the clients involved and to the worker who mentioned it in the meeting.

Another satisfying role involved being very protective of their clients when they had to intervene with EMS workers who were reluctant to get involved with a mentally ill person.

Thus, in spite of the overwhelming stresses associated with attempting to manage the clients' medical care and watching them get sicker and sometimes die, the staff also derive satisfaction when they feel that they have made a difference in the clients' lives, while they lived with their illnesses and while they were dying.

Learning

There are other less dramatic ways in which the participants in this study realize satisfaction in their work with the medically ill clients. One way which is consistent with findings in the literature on the subject has to do with opportunities for learning. There were several ways this occurred.

Several staff "enjoy" the work because it provides an "ongoing learning experience." For some the stimulation came from learning new information. For example, a supervisor who had known since the eighth grade that she wanted to help people, had worked in mental health for so long that it had become "routine." Learning about medical issues presented a new source of enjoyment. Similarly a staff person who did not mind accompanying clients to clinic appointments explained that he "especially liked it when I go to the medical clinic and get first hand knowledge. It's like going to medical school."

Another staff person, who described himself as "open to different ideas," said that the work presented challenges. He found himself observing other staff in order to learn how to handle difficult situations such as when clients refused to take their medications. The work also presented a "challenge" to a worker who described himself as "a problem solver." He found the work "stimulating and intriguing" because "when I hear somebody has a problem, or I see someone in a particular state, my mind immediately goes into gear like how are we going to approach this? What are we going to do"?

For some staff, the learning was about "who these people are, which opened my eyes," as contrasted with the "misconceptions of the outside."

The rewards of the learning extended beyond academics to include personal development. For example, in explaining his "passion" for the work, one young man pointed to how the job

> keeps you learning. They can never send you to a dead end job. It's like okay, I'm getting the book knowledge, but now I need the real life knowledge. And with the medical aspect, it keeps me wanting to learn more because you see the potential growth not just employment wise but also educational wise. I see I can grow and learn as a person both emotionally and educationally.

Satisfactions in Relationships With Clients and Staff

There were several references to the fulfilling bonds staff had with their clients whom they could "never just walk away from".

There were several ways in which the bonds enhanced a sense of self esteem. Speaking of a "difficult, argumentative, noncompliant, whatever you can think of, he is client" who also had a cancer, a worker pointed out that this client still got

> the responses and attention that were beyond baseline. So it shows we're not here just for a check. Besides there's a bond that I've created with these clients. It's something hard to just walk away from. And you know what, if no one else cares, I will. I will. And here I am and it's hard for me to walk away, truly speaking.

The bonds between the staff and their clients clearly enhanced worker self esteem. The staff appeared pleased by the clients' "trust" in them. Especially meaningful was the fact that the clients "make you feel as if what we do here is something that is very special to them and it makes us feel important.." For example, one client would only take his medication from one case manager.

There were also indications that the clients "like they care for you," another way that reassured staff of their value. For instance, clients were known to keep track of when staff had vacation and how many days they would be away. One staff person also proudly described how one time all the clients gathered to greet her when she returned from a vacation. "When I opened the door they were all downstairs yelling Yeah." A female case manager indicated how pleased she was that one client called her "Mommy all the time. Up the street, at the hospital, anywhere, wherever she is, it's Mommy, Mommy. And I'm so short and she's so big!"

While the satisfactions identified by this team derived mainly from their relationships with the clients, staff were also pleased when their abilities were recognized by other professionals. For instance, there was the time when a case manager arrived for night duty and noticed that a client "looked like he was having a stroke because his face looked funny." She accompanied the client to the emergency room where a physician confirmed her diagnosis and congratulated her on being "very observant." There was also the satisfaction of "working in a team, social workers, doctors, case managers, group leaders that helps stabilize these clients".

Another staff person spoke of his commitment to the work and his pride in his willingness to help his clients. The self esteem he derives captures the essence of how valuable he feels the work is and how valued he is for doing it:

> I can tell you an experience I had outside with some friends I used to work with. When I told them about this job, someone said, 'Yo, Joe is working with those mad people! And I'm saying...I just relax and it even gave me more resolve, courage, and strength to say, 'you know what, It's a shame that they're so ignorant about the mentally ill. I want to make sure that I can do something for these people here, maybe especially for the medically ill population. And I have the strength.

Conclusion

Using the concepts of burnout and job satisfaction, two concepts routinely employed in social work literature to understand the consequences of working in stressful work-related situations, this chapter examined the occupational stress of working with chronically mentally ill clients who have co-occurring physical illnesses from the vantage point of their impact on professional performance.

Many of the findings are consistent with the literature on the stresses encountered in both mental health and medical health settings. Physical and emotional exhaustion, emotional withdrawal, and a sense of professional inadequacy were all identified by participants as they discussed their work with their clients. The participants also discussed problems such as heavy workloads due to the paperwork demands associated with charting and government compliance and time consuming medical trips with clients as well as agency obstacles.

These factors have all been identified as correlates of job dissatisfaction. However, while the focus group discussions included many comments about worker exhaustion and feelings of professional futility, as well as indications of problems with overwork and bureaucracy, there were also numerous comments reflecting satisfactions the workers derived from their work with this population of clients. These included finding the work intellectually stimulating with regular learning of new information, and the opportunities for problem solving that kept the work challenging. Helping clients live and die well was another very significant aspect of what the staff found rewarding which in turn enhanced their pride in the work they did, work they felt others avoid. Perhaps most significantly, it appears that these satisfactions equal or at least offset the stress related problems that the staff identified.

Chapter VII

Staffs' Methods of Coping with Clients' Co-Occurring Illnesses

Introduction

This dissertation has explored the experiences of mental health social workers in learning how changes in their clients' physical health have affected them in their professional role, and how this group of professionals handled the stress. The previous chapters identified the factors that the participants considered to be stressful about their clients' co-occurring illnesses and presented a picture of the impact of the problem on feelings of burnout and job satisfaction. The present chapter looks at how this group of mental health staff copes with this professional challenge.

Review of the Literature

Job related stress in social work has received considerable attention over the years, beginning in mental health practice and more recently in medical health settings. There has been a related effort to understand how social workers cope with the accumulating pressures in their jobs. Most of the attempts to understand ways social workers manage occupational stress have focused on the correlates of job satisfaction, an important concern in terms of job performance, retention, and recruitment .

The literature on coping has had less to say about what are the effective ways to handle job related stress. Aside from Pearlin and Schooler's (1978) sample survey of the effectiveness of coping in the four domains of marriage, parenting, household economics, and work, there has been "surprisingly little empirical research on the effects of coping in natural settings" (Shinn and Morch, 1984, p. 228). One exception is the recent study by Gilbar (1998) of the relationship between burnout and medical social workers' coping strategy involving a "sense of coherence," coherence being an "enduring feeling of confidence" (p. 41). Gilbar found that health social workers who have a strong sense of coherence experience less burnout than those with a weak sense of coherence. While there were earlier attempts to describe the coping strategies used by social workers in cancer settings these were more descriptive than empirical (Davidson, 1985 and Koocher, 1978).

Additionally, while Pearlin and Schooler found that various types of coping worked in reducing strain in the areas of marriage, parenting, and domestic economics, these had little effect on the strain resulting from work. In their discussion of the "bewildering richness of behavior" that constitutes the structure of coping, the authors made the point that "individual coping is least effective in areas of life such as jobs" (p. 10). Their explanation, which has been shared by other researchers such as LaRocco, House, and French (1980), is that jobs are not only impersonally organized but that the forces affecting people at work "are beyond the kind of personal coping we have been examining" (p. 10).

The authors are not saying that individual coping has no place in managing occupational stress. For instance, they did find that one way to offset the strains of job related stress was by devaluing the intrinsic rewards of work. However, they also noted that keeping the work secondary in importance was not very successful (p. 11). The finding in the current study that the meaningful nature of their work was a source of satisfaction for the participants would tend to suggest that such a strategy would certainly not work with this group of professionals.

In their study on the limits of individual efforts to cope effectively with occupational stress, Menaghan and Merves (1984) also cautioned that the power of individual coping with occupational stress "should not be overstated." While concurring with earlier researchers that job stress is embedded in larger organizational issues, these authors also noted that the magnitude of the occupational problem can result in its being "impervious to individual coping" (p. 419).

Shinn and Morch believed that Pearlin and Schooler's finding is "not simply a statistical accident" (p. 29). They contended that "individual coping strategies "may be less potent than those we will call "higher-level strategies" (p. 228). Consequently, they proposed a "tripartite model of coping" which recommends several levels of coping strategy including "groups of workers and entire organizations" (p. 238). This model finds support in comments made by several researchers. Pearlin and Schooler (1978) asserted that the problems in occupations "may require interventions by collectivities rather than by individuals"(p. 18). LaRocco and his colleagues concluded that "job-related stress and strain are primarily affected by job-related sources of support particularly from co-workers and supervisors" (1980, p. 213).

In their work on stress and coping, Lazarus and Folkman (1984) emphasized that there was not a hierarchy of coping strategies. They stated quite clearly that because not all aspects of the human condition are amenable to mastery, "coping processes that are used to tolerate such difficulties, or to minimize, accept, or ignore them are just as important in the person's adaptational armamentarium as problem-solving strategies that aim to master the environment" (p. 139). This chapter illustrates the coping strategies employed by social workers when their mentally ill clients become physically ill as well.

Individual Coping Responses and Resources

The content of the focus groups established that in coping with the problems they faced in their work with medically ill clients, study participants demonstrated a broad range of coping strategies. There were examples of individual efforts as well as the use of group support both informally and in formal meetings. Some of these were regular team meetings while others were organized for the specific purpose of getting mutual support. The staff also gave examples of how the agency helped its stressed workers by providing specific assistance and by encouraging an agency norm about client funerals.

Respondents described a range of behavioral, cognitive and emotion efforts to handle the additional stresses of their work with clients with co-occurring illness.

Individual Coping Responses and Resources

Cognitive Strategies

There were many expressions indicating the cognitive processes of denial and minimization, as well as rationalization. Sometimes staff would play down the import on them of a client death as in

> when we do it every day, I think after a while we start calling them 'little things' even though at one time when we started out they were huge, even some of the things around a death.

Another worker explained how he would feel bad when someone died, but he insisted that "death doesn't really affect me." He explained that "I feel bad, like I feel like 'Damn someone so young, they had to die'. But after a day or two I get over it."

In order to cope with the ongoing stress of her young client's progressive deterioration that would eventually end in her death, a staff member poignantly described the following pattern of denial:

> I thought she was coming back even paralyzed, even with cancer I thought she was coming back. I guess I like closed my mind to, you know- and then she had bone marrow cancer and brain cancer but I would say ok, she will come back here to live. I just didn't get it in my heart. Somebody told me she had bone marrow cancer and I know that's near the end, like nobody survives that except if they have a transplant and she didn't have a transplant. I still thought she was coming back and I was still shocked that she died! Even though I knew how sick she was.

Shutting off feelings, rather than denying them, was the way one young man coped with his reactions about clients who had died. He explained that

> it just happens. Hey, what can you do? Dwelling on death, you can't linger on it or keep thinking about this person, being sad all your life.

The use of denial was also evident in some of the staff's clinical work. For example, a staff member acknowledged that although he certainly tried never "to lie to clients," he nevertheless was guilty on occasion of "joining in their denial" of the serious problems they faced. For example, in his work with a client who was dying of cancer, this worker admitted to "joining in his denial" by talking with him about various concrete or mundane issues, "any problem but his cancer" which was of course the client's most serious problem.

There were several comments about another clinical practice that workers relied on to help them cope with their own feelings and reactions. While not technically denial, the practices did allow for the necessary emotional distance that could enable denial of their own fears. One worker explained how eliciting the clients' feelings helps her "discharge" her own grief reactions. She stated that:

> Sometimes it's easy, though, to be with the client, when you're working on the same issue. At least for myself, I use my own feelings, and I really feel the empathy more. And if I guard against just my taking care of my needs in working with the client, usually I feel better anyway. If I'm clear that I'm not dealing with my own need, and I work with the client on verbalizing their feelings and talking about their loss, it usually discharges my feelings anyway. Even when it's such a close issue. Or we help them say what they're feeling because we're so close to it that we're feeling it.

The foregoing comment may almost be interpreted as suggesting that through identification the worker can allow herself to feel and work through her own emotional anguish, as long as she does it in the context of helping another. This idea was also touched upon by another worker who was somewhat more clear in her understanding of the manner in which addressing the needs of the clients helps her to cope with her own loss:

> I find it easier listening to them expressing how they feel. It's sort of...how should I put this now? It gives me a little distance. Because I'm there for them; I have to listen to them. So I sort of detach myself from that a little bit, just to be there for them.

One notes that it is a well-worn aphorism that those in the helping professions help themselves when they help others. The observations of these last two staff members would certainly appear to support this suggestion.

Another frequently mentioned behavioral coping response was to stay detached, "to pull back," as one person called it. When a worker described himself falling into an "emotional morass" once he realized one of his clients was deteriorating rapidly, he said the "only" thing he could think of doing was "to just cut it off, make myself numb." He also felt that some of his colleagues empathized too deeply with their medically ill clients. He did not think that this degree of involvement was appropriate explaining that one had to "draw the line" in order to cope.

A staff person reported that her therapist's permission to her to be more self-interested had helped her to cope. She now believed that "it was okay to care, but you have to take care of yourself and your feelings too."

Another woman maintained her emotional distance from a client by continuing to remind herself of the client's difficult character:

> Even though I liked her and there was some connection, I wasn't really really... I didn't let myself get emotionally attached. It was because I knew-in a sense I was but..I tried not to be because I knew she was sick. (sigh). There was just something about her, I liked her but part of me really didn't.

There were a few illustrations of how being detached affected the quality of the care clients received. For instance, when a worker was "teed off" by a client, he said that he was more likely to draw the line on how much he would extend himself:

> If you really like that client, you go out of your way. But if you have a so-so feeling against that person, you might pass--. I mean you do your job--I personally--Let me keep it on me. I'll do my job to the minimum. I'm just doing my job enough to get you what you need.

Rationalizing the reasons for a young client's death in order to tolerate the reality of it is evident in the remarks of the staff person who worked with her for several years. The remarks illustrate how the worker romanticized and rationalized her own thoughts and attributed them to the client. Her comments ranged from "she just decided to surrender her soul and that's when she died" and "I told the clients she was in a better place and she wouldn't want to come back here" to "I think she was getting tired too of being sick, of all the pain, of all the medications, of people always sticking her and poking her. She just wanted it to be over."

When a favorite client died, one worker indicated that she coped with her grief by distracting herself with "busy work." She took it upon herself to make all the arrangements for a memorial service. She said that "all of that stuff that we had to do...made us...at least made me...feel that I was occupied."

Use of Humor

There were also several references to the importance of humor to "lighten things up around here." In one focus group, when the team was asked how they coped, a young social worker retorted in a deadpan voice that he took medication. After a long pause he said "joke! The medication is having a beer, you know." This was a reference to an earlier discussion about the ways the team sometimes socialized together, for instance going bowling and "once in a blue moon having a drink together."

For the staff at one of the residences, humor was an important way to "release tension." In fact, one staff person said that joking "was a prerequisite for working here" because it was used so extensively. At times the humor was playful, as when staff created sitcoms like "the set of E.R." and assigned roles to different clients. At other times the joking was more mocking. For example, the staff joked about clients doing improbable things like making a movie or directing a play. They also did impersonations of clients:

> Like some of the residents here, they have had extensive histories. Like one was a singer. And we would say. Okay, we could see her singing this song. And this is how she would react. Sometimes it's not funny, but we have to make jokes out of bad things to keep our sanity and just to cope.

One of the staff in this team was uncomfortable about what she thought might be perceived as unfeeling or harsh about the humor. She explained how important this practice was to her as well as her colleagues:

> It allows you to laugh. You might be having a bad day and need a real good laugh, and that laugh just did it. So you get back to doing whatever it is that you needed to do. So it refreshes you sometimes. Because sometimes it's hilarious. Even when I'm walking home I'll just think about something we may have said earlier that day and I'll start chuckling to myself.

One person summed up the importance of humor for coping with the stresses he encountered when he said quite simply and directly: "without humor, you couldn't do this job."

Learning

Learning new information was also a frequently mentioned coping behavior. For one case manager, having information was "reassuring" because then "at the very least I can know myself, first hand what is going on." This explanation was repeated in the comments of another staff person. Acknowledging that she would get anxious at the prospect of not knowing something required to help a client, "you never know what I should or what I saw," she had begun to take notes during the times when she accompanied the client to his medical clinic appointments.

Personal Resources

In addition to the coping responses that the participants described, they also referred to various coping resources, such as personal characteristics, beliefs, and capabilities, that enabled them to cope effectively with the challenges posed by their medically ill clients. Personal makeup was evident in the comments of a supervisor when she described her approach to the work:

> When I work with the clients I try to put them on a track that's the best for them. When they're on track, it's like everything runs smoothly. When clients have a problem I think about how to get them out of it So it's like I'm never worrying. I'm never...I'm always in an action role in a way. I don't know how else to explain it.

Another staff person had a similar explanation:

> I think that I'm constituted as a person who is not a worrier. When I finish something I move on to the next thing. I don't ruminate and worry about what I am going to do.

A positive sense of self and the ability to approach work optimistically was another personality trait that clearly enhanced a staff person's coping. She described how she learned from her mistakes as follows:

> Even if I actually, should I say, do something like use poor judgment, I don't look at it as something to put me down. I can learn from that experience and do something differently that would be more helpful to the clients the next time.

Several staff described enjoying challenges. For instance, a supervisor described himself as a "troubleshooter" who tried to "forsee any possible outcome that could be disastrous." He therefore approached the work as a "challenge." In a similar vein, a young worker gave an example of how he viewed working with clients in order to have them be compliant with medication. "I find it challenging trying to figure out how I can talk to this person and not trigger them so they will do what they need to. So now I am looking at different ways to communicate with each and every individual separately. A person is one way; B person, another.

Professionalism as a Coping Resource

Beliefs about the value of the work they do, even when they are under duress, as well as viewing themselves positively because of their "compassion" and work ethic were also key elements in the way several staff managed the stress. For instance, in describing a client with cancer who "was a pretty difficult person, argumentative, noncompliant, all of the above. Whatever you can think of, he is," one worker pointed out that this client still got

> the responses and attention that were beyond baseline. So it shows we're not here just for a check. Besides there's a bond that I've created with these clients. It's something hard to just walk away from. And you know what, if no one else cares, I will. I will. And here I am and it's hard for me to walk away, truly speaking.

Several staff mentioned that they relied on their professional ethics to help them manage medical situations that they found unsettling.

> It's like, when it's a friend or someone you know personally outside of here, you can use your option. I can choose to leave the hospital if I want to. Or if it's too much, I can explain to them why I feel uncomfortable. With a client you can't do that. You have to sit there with them whether you want to deal with it or not. Part of your thing is to go visit and check up on them and see how they are doing. Whereas if it was a friend I'd probably just call and they would know I am not crazy about going there and they would understand. But I have to put my personal feelings and wish aside and just go, go deal with it.

Sometimes the professional ethics seemed more like professional norms. For example, a worker explained how

> You could just be leaving and you see something you have to do for one of these clients. You want to go but morally, ethically you just kind of turn back and say I've got to do this I cannot let that happen. Got to turn back. Because if M. knew I walked past the stairs and I went home---.

Social Support from Colleagues and the Agency

There were also references in the focus group content to Shinn and Morch's "higher level strategies" which involved "collectivities" or supportive groupings. Several staff members described the value of community support and mutual help from other staff and also from clients at times. A worker explained the community support as follows:

> Because we were in a community, and because there was all this to do, I think it helped the process. Rather than just sort of feeling isolated and totally helpless, like I did with a friend of mine who died recently. (With that friend's death) there was no support. (Here,) there was a lot of support from staff...a lot of stuff going on. And the clients supported us too. That's how I felt. Oh, yes, they did, because we all went through it together.

Staff members also noted that the agency wide, staff planned memorial services that were always conducted when a client dies are helpful to the development of the sense of community and mutual support. One staff member described the memorials as "gorgeous, beautiful services."

Information was also exchanged in regular staff meetings which, one staff person pointed out, have become places to "discuss what we've learned about this individual and to share ideas." One team also used staff meetings as a way to support each other's coping. This was noted by a staff person as follows:

> I think that a good way to relieve stress is by having these meetings, by talking. What we do is sit down as a staff and we discuss anything people want to bring up, like any behavior patterns or new problems or possible decompensation. We discuss everybody. And it's a good way to get on the same page, to be a unified treatment team, to release stress.

Another worker emphasized how the teamwork aspect of the meetings is very reassuring and bolsters their ability to cope with the demands of the work.

> Also, when you have one shift relieving the other you have to fill them in. So you're bringing them up to date in these meetings. So personally with me, once I leave for the day I'm feeling like okay, now it's in your hands. It's not just out there. Somebody else is taking care of it. So I can be okay because I know it's an excellent staff. I know they know what to do and how to handle it. So the stress is relieved.

There were also comments about agency level support. Several staff referred to how the agency regularly made available bereavement consultants to individual teams when clients died. The agency also acknowledged the importance of the community-wide memorial ceremonies by providing money for food and other needed supplies and arranging for staffing coverage. The agency also helped with the transporting of staff and clients to the funeral services of clients from agency programs.

Conclusion

This chapter has reviewed the numerous ways the staff of Vistas cope with the stresses of their work. Lazarus and Folkman observed that there are many stressful life events and conditions which can not be mastered. In such instances, there are strategies that enable people to tolerate, minimize, accept or ignore them; in other words, cope. The participants in this study did just that. The focus groups revealed how the staff use a wide range of coping responses as well as resources in order to manage the stresses associated with their clients' co-occurring illnesses. There were also comments about how the staff valued opportunities to meet in groups with colleagues. Some of these collective activities were work focused team meetings organized for the purpose of exchanging information about clients. Other work related groups were arranged as needed to discuss issues like the death of a client. The staff had also developed a unique group experience in the form of regular memorial services for clients who had died. These services, created by this staff and with the help of clients, were an expression of the strong sense of community that was valued by this staff and encouraged by the agency as a whole. Lastly, the administration at Vistas had a role in fostering staff morale and coping through the bereavement group counseling they provided to staff and through their assistance with the memorial programs.

The range of strategies utilized by the staff, the organizational support described, as well as the importance this staff gives to the mutual support they experience in their team meetings and the larger agency community suggest why this group of staff continues to function at a highly professional level, providing quality services to a very difficult population of clients.

Chapter VIII

Summary, Implications and Recommendations

Introduction

The purpose of this qualitative research study was to explore the experience of mental health professionals working with persistently mentally ill clients who had either co-occurring, continuing physical illnesses or who were dying from them. In addition to describing the nature of this occupational challenge, the study sought to document how the staff negotiated these complex demands as well as determine what contributed to effective coping for practitioners faced with this "dual nightmare."

The study used focus groups as a way to generate productive group discussion about these issues. It was my goal to have the participants' discussion of their perspectives on this subject establish new practice-related knowledge about their experiences, using their own words to report their practice behaviors, personal attitudes and professional values.

Also, the study used a sample of staff drawn from the agency's two settings, residential and day treatment, in order to learn more about the nature of the "organization-client relations" at this agency. Specifically, I wanted to understand whether there were differences in the types of relationships at the two sites, as well as what affect the structure of particular organization-client relationships at each site had on the "interpersonal processes" between the clients and the professionals and, in turn, on the degree of stress staff experienced.

This final chapter will summarize the major study findings, discuss the implications of these findings for social work practice and education, and make recommendations for further research regarding how physical illnesses in the chronically mentally ill impact on practice.

Summary of Findings

The present study established that regardless of whether staff worked in the day treatment clinic setting or in a residence, with clients in scattered sites, or under one roof, they all maintained intense, long term relationships with their clients. This longitudinal orientation in which the staff had an extended interest in the client and his or her life appears to be an unplanned by-product of Vistas' philosophy of providing the mentally ill clients integrated clinical services under the same umbrella and also 24-hour, staff supervised housing in a homelike setting.

This arrangement ensures the coordination of clients' clinical care and also provides them with structure, continuity and security. Unfortunately, however, the study made clear that this arrangement, where the agency through its staff has 24 hour responsibility for its clients, can result in problems which were not anticipated or planned for. A case in point is the impact on staff's conflictual emotions and on their professional functioning when their mentally ill clients develop physical illnesses that require staff involvement. In addition, the study established that the physical illnesses of these clients placed enormous demands on the staff that do in fact affect and alter their social work practice in numerous and stressful ways.

There is existing literature documenting that social workers demonstrate effective ways to handle the behaviors customarily associated with chronic mental illness. However, those same patterns of disordered thinking, poor judgment, and psychotic behaviors interfered with clients' ability to manage their own medical care. Clients were also noncompliant due to psychiatric symptoms such as paranoia. Necessarily, the staff were required to take over medical management but reported simultaneously feeling parentally responsible while also professionally inadequate, especially when medical noncompliance seriously threatened clients' lives.

The study also established that mental health professionals experienced intensely negative emotional reactions to the physical illnesses, dying, and deaths of their clients as well as feelings of professional helplessness in the face of their clients' physical suffering.

Lastly, there were strong indications that social work staff experienced considerable burnout and job dissatisfaction as a result of numerous job related pressures. These included increased workloads, time consuming attention to medical problems over psychiatric problems, administrative obstacles, and lack of recognition for their efforts.

While the study demonstrated that some clients' physical illnesses and their mental illness related attempts to thwart the professionals' efforts to keep them healthy presented significant occupational strains, staff were able to manage these demands relatively effectively. Although they struggled with a variety of stressors, staff demonstrated an impressive repertoire of coping responses and resources.

The Impact of Mental Illness on Medical Care

Throughout the fucus group discussions, staff made many references to the ways in which clients' mental illnesses hampered their medical care and frustrated them

Mental Status

A major problem cited was the way in which clients' confusion and disorientation, poor judgment, and concrete thinking make it extremely difficult for them to manage their own prescribed medical regimens or to follow through on their medical appointments. Clients were also described as lacking the motivation needed to follow medical regimens and lacking insight and/or understanding regarding the seriousness of their illnesses that might allow for greater cooperation.

Accordingly, staff described a pernicious kind of noncompliance arising from the clients' paranoia and delusional thinking about their illnesses, their antisocial and oppositional tendencies, and their frequent impulsive behaviors. Consequently, even when staff felt they had to "step in" and intervene, their clients were often "fighting me at every step."

The result was that staff often reported feeling "pissed off." On the other hand, respondents indicated that they could just as easily feel guilty about being angry recognizing that clients adherence to medical requirements was attributable to mental illness rather than volitional antisocial choices.

In Loco Parentis

Nonetheless, the ways in which psychiatrically induced thoughts and behaviors hampered clients' abilities to manage their own care or participate cooperatively with staff created practice-specific stressors for participants in this study. Since most of the clients at the agency did not have family, the staff assumed an *in loco parentis* position. Consequently, they described feeling a heightened sense of responsibility for managing clients' medical conditions and a sense of "mission" for keeping them alive. Because the staff had insufficient medical knowledge and nonexistent training in working with the psychosocial needs of medically ill individuals, they also reported feeling professionally inadequate.

The issue of responsibility for managing clients' medical care and "making sure they stay alive" also created in staff a sense of "emotional vulnerability." For some, this was due to their commitment to achieving the "total health" of their clients. When this was not possible, some staff reported being "tormented by feelings of guilt." Others were frustrated and felt "at a loss" because they were "not equipped to help them" as they were when the problems were psychiatric.

The parental nature of these relationships, the staff's sense of responsibility for their clients' lives, and the incompetence the staff felt differ from the feelings of social workers in medical settings. This group also have intense contact with their physically ill clients but they do not report the feeling same type of inadequacy. This may be due to the fact that hospital based social workers work in a "secondary practice setting" where decisions regarding patients' fate are the concern of physicians. By contrast, the social workers in this study clearly feel a primary responsibility for keeping clients alive as well as psychologically healthy..

Other mental illness-related problems reported by staff included clients' self-destructive behavior in the form of overeating and heavy smoking and the effect of some psychotropic medication on excessive weight gain that contributed to health problems such as diabetes. In the extreme, staff expressed concern that awareness of a new and serious physical illness could send an already mentally fragile client "over the edge" into a depression and/or suicide. More commonly, however, having a physical illness tended to make clients regress, complicating efforts to help them develop self care skills and functional independence.

The Impact of Physical Illnesses on Staff

The participants spoke vividly about how they were intensely affected by their clients' physical illnesses, the process of dying, and client deaths.

Exposure

They talked about their fear of seeing "horrible," "disturbing" physical illnesses and the pain of "being involved in the process of watching someone die," as well as the "shock" of medical emergencies. At times, one social worker said, it felt like "more than I can bear." Workers also remarked on how helpless they felt because they could not relieve their medically ill clients' pain, both physical and emotional. Several staff simply stated that they were "not trained to watch someone die." Similarly, several staff either explicitly stated or stated indirectly that they had specifically chosen to avoid working with physically ill individuals. Still others had intentionally left medical settings to get away from the suffering they had watched.

The almost constant exposure to physical symptoms, lingering physical deterioration, sudden or expected deaths, and grief provoked in many staff an awareness of their own mortality, an awareness that often left them feeling "baffled" and "uncomfortably vulnerable." Study participants described many occasions when they felt flooded with "undefended feelings" while working with a physically ill client. These feelings could occur at "unexpected times."

Service Problems

Service problems associated with clients' physical illnesses included the level of demand that it placed on the staff. These included accompanying clients to medical appointments and keeping accurate and updated records on medical conditions and regimens. Staff also reported problematic contacts with outside medical providers whom they did not know and with whom they had no ongoing working relationships.

Burnout and Job Satisfaction

Exhaustion

Focus group discussions conveyed a general sense of how burned out many of the staff felt. Several participants spoke of "experiencing ongoing stress" and "almost continuous mental strain." One worker said it seemed "there was never an end." As an example, she offered a client who had improved emotionally so that she "was now a part of us" and then had an abnormal mammogram which required a biopsy. Another said that she had gotten to the point where she was simply "frustrated with the whole situation." Other comments referred more specifically to the various components of burnout. Emotional exhaustion was evident in the remarks of a caseworker who felt that he was being "inundated with death" so that "the cumulative effect of so many deaths is wearing me out."

There were also references to the exhaustion created by the amount of documentation required for the physically ill clients because " it takes twice as long." Several staff reported that they were sufficiently stressed that they had begun to feel physically exhausted or were experiencing physical symptoms.

Lack of Accomplishment and Feelings of Inadequacy

The staff's feelings of professional inadequacy and lack of professional accomplishment were reflected in the perceptions of staff members that their efforts were largely futile, that they were "powerless" and "clinically helpless." The inability to "protect" clients or get them to consistently follow medical regimens led one staff person to acknowledge openly that she had sought professional help for herself. This worker described her sense of complete frustration with her own inability to achieve any meaningful change in her clients' self-destructive eating behaviors:

> I have to talk to them. It feels so bad because you start to think, "Am I getting through to them? Do they understand? Do they care? Do I understand more than they do?" And it becomes a lie. Because you want them to and they don't.

Another worker, who described feeling like a "hamster on a treadmill," had even considered leaving the agency.

Witnessing the suffering and ultimately the deaths of so many clients created profound feelings of professional inadequacy. A case worker expressed the sense of futility that overwhelmed her when she thought about the death of one of her clients. This worker indicated that she felt bad because she "wasn't able to do anything." Her sense of hopelessness was sufficient to keep her from sleeping, and she found herself "thinking obsessively of all the other deaths" she had experienced during her life. At least one supervisor spoke of feeling ineffective at helping her staff handle the demands of the work with ill and dying clients saying that she "wished she could take care of them better."

Depersonalization

Additionally, there were several responses reflecting the dimension of burnout referred to as depersonalization. Several staff acknowledged efforts to distance themselves from clients because as one person explained, "it's a real kick in the pants when you get close and then they die." Other comments on this topic included "initially you get attached, but as time goes on it becomes just a job" and "after a while you just get numb...you don't care." Several staff even stated explicitly that they would "never again get so close to clients."

Workload

Many of the factors which have been shown in other studies to correlate with job discontent were also identified in the discussions including overwork, time consuming tasks related to clients medical needs, and "tons of paperwork."

Participants referred to being "spread too thin" because of the heavy workload. A supervisor described feeling like he was "running around like a chicken without a head" because there were so many tasks to get done for the medically ill clients, activities that were additional to the regular work that staff were trained and hired to do. For instance, a case manager who said he was "overwhelmed" by "pressures coming in at all angles" explained how:

> I may be concerned with client A's medical and psychiatric problems, and I want to get that all documented. Then client B comes in and has an array of medical problems that I have to deal with and write down. It just becomes overwhelming.

The time consuming nature of the work with medically ill clients was a particular problem. A case manager commented on how he was "falling behind." He attributed this problem to the number of times he had to accompany clients to "time consusming" medical appointments while juggling the needs of both other medically ill clients and also attending to his "regular" clients. He related the following:

> When you have 16 to 18 clients and at least 8 of them have physical illnesses, it just gets overwhelming when there are two major dimensions, the mental and the physical. People get sick. You really can't help it, but then they have to take back in some other way.

Other staff talked about the number of "mundane" but important things they had to do for their medically ill clients such as bringing books and extra food to them when they were hospitalized. Picking out a coffin or funeral clothes are hardly commonplace jobs and they were time consuming and stressful.

The paperwork documentation was another "real pain," because notations about clients' medical conditions had to go into multiple forms as well as treatment plans in order to be compliant with the "scrutiny" of outside agencies.

In addition to the problem created by stressful workloads, the participants in this study cited several organizational deficiencies which led to dissatisfaction with their jobs.

Agency Obstacles

While there was some mention of outside stresses as with "a government that doesn't help anymore," the majority of the comments reflected frustrations with the agency. Staff described a range of problems in this area including under staffing, a lack of agency concern or recognition of the difficult work they were doing, and inadequate interagency communication in the form of nonexistent procedures.

The participants identified staff shortages as a major problem. Frequently there was inadequate coverage in the residences which meant staff worked overtime and sometimes gave up vacations. But the agency was described as reluctant to pay for the added hours worked. "We have to argue for over time because they don't like to pay it."

Sometimes staff had to spend "precious time" accompanying clients to day long medical appointments because of the lack of ancillary staff to do this. Additionally, with the very limited night staff, clients had to be sent to emergency rooms in ambulances unaccompanied by staff which made staff feeling extremely guilty for "abandoning" them.

Several staff members commented that they did not receive sufficient recognition from administration for the difficult work they did. The staff also perceived the administration as distant and arbitrary, often making decisions "without enough knowledge of the realities of working with this client population" or without input from the staff. The agency was "not health conscious" because it lacked nutritional workshops. It was also charged with "looking after its own needs" so that offices for "billable services" such as clinic visits that were given priority over other types of healthy activities, including a gym that could be used by both clients and staff. This was an especially sore point as the agency used to have a gym but it was in fact made into individual offices. Other critical comments focused on the agency's failure to develop policies regarding patient confidentiality with respect to medical conditions, inadequate mechanisms for communication of relevant information about patients' medical conditions from one staff member to another and between one agency division and another.

Staff Satisfactions

Another finding, that staff derived satisfaction from their efforts to help their medically ill clients, is consistent with the image of social workers as altruistically motivated and as a service oriented profession. What is striking however is how the participants were able to derive satisfaction even in the face of client suffering and death.

Helping Clients Live and Die

The satisfaction of helping clients is pretty straight forward in the comments of a staff person who worked with a noncompliant client and pointed out how

> great it is to get a report from the doctor that he's doing fine. Or when a client is going to self med. When you see actual progress, that's a reward. Even being able to have communications with the client, that they are open to it. Not necessarily saying that their blood pressure is going back to normal next week, but now we can talk about it. The moment they begin to open up about it and have discussions about it, I think that's good, that's satisfying.

But this worker's following remarks reflect the ability to achieve a sense of accomplishment in even the most difficult circumstances. She pointed how good it felt making them more comfortable emotionally even when they were deteriorating, frightened and dying.

Similar convictions were evident in staff members accounts of the success they had helping clients "blossom" and reclaim lives spent living self destructively on the streets, providing "a home as well as a home life" to many, and "giving them something they've missed," to individuals who in many cases never had these opportunities before. These satisfactions seemed to make up for - or at least offset - the pain and suffering the staff regularly observed. They also buffered the sense of inadequacy staff felt when clients died.

Being Valuable

Additionally, there were many expressions about the bonds clients and staff formed and the gratitude staff received from their medically ill clients. In particular, "being important in clients' lives," being valued by them, was also a rewarding part of the work even though this could also be a "huge responsibility" at times. Satisfaction also came in the pride several staff expressed regarding their ability to work with a difficult population avoided by many people and their willingness to help even the most recalcitrant and paranaoid clients when they became physically ill. Finally, there were also several references to the ways in which physical illness added "variety" to the work, provided opportunities to "learn new things" on a regular basis and presented daily challenges of solving difficult problems. All of these were valuable ways to cope.

Coping Strategies

Despite the many stressors, study participants described using a range of cognitive strategies, behaviors, perceptions, and collective strategies to effectively mange the demands of the work.

Cognitive Coping Responses

Cognitive coping responses were frequently mentioned and took many forms. These included recognition of or coming to terms with the limits of professional ability, validation of the need for periodic emotional distance or detachment from clients, and active denial of the realities of death in the form of rationalization or projection, i.e. "he's in a better place;" "she was just tired of all the suffering and wanted it to be over." Staff also acknowledged that activities directed at continuing a client's work through the creation of a poetry book or portfolio of drawings was a form of denial since it was a way of "keeping him alive, it just goes on and on, it's still going on." Similarly planning a memorial service served to distract staff from the harsh reality of a client's death. Information and learning, either from the clients themselves, from attendance at medical appointments, or from colleagues represented another cognitive way to enhance coping through a sense of competence.

Use of Humor

Another frequently mentioned coping strategy was the use of humor, often when working with clients, or the ability to see humor in even the most difficult situations. There was some concern in one particular residence that at times they were not empathic because their humorous diversions might lean toward mocking the clients. But the staff defended this activity as both necessary and effective.

Clinical Work

Focusing on the clinical work they did with their physically ill clients also provided staff a cognitive strategy for coping. For instance, eliciting clients' feelings helped a worker "discharge my own" and while "trying not to lie," another staff person described "keeping the delusion alive by joining with his denial and staying concrete." It should also be noted here that several of the satisfactions that staff found in their work with these clients also served to help them cope. Among the strategies mentioned that served this purpose were maintaining professional objectivity as well as reliance on professionalism and professional ethics to guide behavior. Closely related to this was the emphasis staff put on the belief in the value of their work with this population and their pride in working with a population that others found "depressing" and therefore avoided.

Innate Abilities

Several participants inferred or explicitly stated that character or personality based resources helped them cope. There were many remarks about being a "troubleshooter," a "problem solver," "not a worrier." Other self descriptions included an intuitive "dedication to helping," a tolerance for "dealing with upset people," an "optimistic" outlook, and a resilience in the form of self awareness, "it's okay to take care of oneself," "we have to pull back at times," that did not interfere with a sense of competence. Having confidence in one's expertise, being seasoned, and approaching work as a challenge were also mentioned.

Collective Activities

The staff also created and utilized collective resources. There were informal groupings for "venting feelings and being heard." The formal staff meetings were perceived as the most helpful and appropriate venue as fellow workers were familiar with the problems and there was the potential to benefit both intellectually and emotionally from the discussions.

Agency Supports

The agency also encouraged and helped to institutionalize community wide, supportive practices. The most noteworthy were the memorial services for clients who had died. The memorials were planned and attended by a community of staff and clients where mourning was acknowledged and shared. This agency also provided bereavement consultants for staff individually and in team groups following client deaths.

Implications and Recommendations

Overall, the value of this study lies in its clear delineation of the occupational stress for social workers created by physical illnesses in the chronically mentally ill. The study has also established that the stress is complex and multi-faceted. Exposure to physical symptoms, progressive physical deterioration, and death powerfully affect staff's emotions. This is true for social workers in health care settings as well. However, unlike their colleagues in the "secondary practice setting " of the hospital who do not have primary responsibility for the patient's physical health, participants in this study believe they do. While mentally ill clients cannot manage their own medical care and need the staff's supervision, they often thwart the professionals' efforts. Consequently, feelings of inadequacy challenge professional competency as well as morale in professionals who find themselves supervising medical regimens, observing physical symptoms, and attending to the emotional needs of dying clients. Taken together these stressors contribute to feelings of burnout and job dissatisfaction that can affect both the quality of patient care as well as staff retention and turnover. The complexity of the problem also indicates the need for new forms of education, research, and organizational innovations.

Recommendations for Social Work Education

The findings of the present study clearly suggest that schools of social work have a vital role to play in preparing students for practice in this changed mental health environment. The current profile and needs of mentally ill clients require educating students with new knowledge and skills to meet the challenges and demands created by these clients' co-occurring physical illnesses. This finding is consistent with the recommendations of authors (Berkman, 1996, Ridgely, Morrissey, Paulson, Goldman, and Calloway, 1996, Volland, Berkman, Stein, and Vaghy, 1997) writing about the need for social work educational content that reflects current practice issues in the "emerging" environments in which social workers practice.

It is beyond the scope of this study to propose particular teaching and training models. However, the study's findings do identify practice issues and needed skills which participants indicated their education had not prepared them for. This opinion, which was widely shared by staff in several sites, lends credence to Kadushin and Egan's (1997) observation that "although the health care environment has changed rapidly during the 1990s, there is no current information on the content taught in health care practices" (p. 213). The study's findings also suggest that continuing education efforts should be directed to current mental health and health practitioners as well as case managers.

Mental health professionals need a theoretical framework for understanding the psychosocial aspects and stages of physical illnesses and normative coping. This knowledge would be helpful in the assessment of their clients' behaviors and responses. For instance, denial as a way to cope with the emotional impact of a physical illness can be a normative response that does not indicate dysfunction. The emphasis in health care is on enhancement of coping. Preexisting illnesses are only a problem when they compromise coping. The framework for the staff's practice with these clients must therefore include an understanding of the interaction among psychological, social, cognitive and biological factors. Also, this staff needs to learn communication skills and intervention strategies that are specific to the needs of physically ill and dying individuals and integrate these practice skills with the expertise they already have.

Additionally, it is necessary for social workers in mental health settings to integrate physiological knowledge into their practice with clients. These professionals must have knowledge of the illness or disease and its effects in order to distinguish physical symptoms from psychological ones or from reactions to psychotropic medications. This recommendation does not mean social workers should be diagnosing their clients' physical conditions. However, knowledge of symptoms and reactions is just as necessary as understanding reactions to psychotropic medications. This is particularly important since the staff are responsible for monitoring their clients' health.

General medical hospitals are seeing many mentally ill clients in their outpatient clinics and inpatient units. This fact suggests the importance of training current medical social workers and those planning a career in medical settings for the specific knowledge and skills needed to work with clients who may exhibit disturbing or noncompliant behavior. This training would ensure that clients have the advocates they need in the medical setting in order that they are properly seen by medical staff who may discount their complaints or overlook them. Training should also familiarize medical social workers with the psychosocial needs of mentally ill clients, for instance the role of agency staff and clients as surrogate family with a role to play in a physically ill client's care. These social workers need to understand how a mentally ill client's perception of his or her disease as well as his behavior affects the ability to cooperate and to cope and ways to work with these clients. Lastly, training about the psychosocial needs of mentally ill clients might increase medical social work staff's comfort with a difficult population they are not familiar with, in turn improving the care they can provide.

Social work education should teach the foregoing practice knowledge and skills on several levels. Social work education at the student level should consider integrating concepts about the physical status of mentally ill individuals into current health and mental health sequences along with the requisite skills to work with this population. The knowledge and practice skills could fit into many areas in the curriculum including aging, chronic illness, long term care. The problems created or unanticipated by earlier public welfare policy also have a place in administration and policy electives. The current profile of these clients and the demands on social workers demonstrate the complex ramifications of planning. Courses should be given at the post graduate and certificate levels in order to make the information available to practicing social work professionals and case managers like those who were a part of this study.

Recommendations for Agency Practice

Study findings that organizational factors were both positively and negatively associated with stress on staff suggests that agencies must also get involved in addressing this occupational problem. This recommendation is consistent with Himle and Jayaratne's 1990 study on perceived competence and work stress. While these researchers found that practice mastery moderated some aspects of burnout, it did not affect other job satisfaction variables such as role conflict and overload. The authors hypothesized that there are a variety of occupational and organizational stressors correlated with work stress so that other interventions besides education are needed.

Another finding supporting the potential for the effectiveness of agency involvement comes from La Rocco, House, and French, (1980). Their research showed that indicators of job related stress are primarily affected by job related sources of support.

Participants in this study suggested several agency level interventions. There were recommendations for hiring more staff, at least for the specific task of accompanying clients to medical appointments, wellness seminars, for both clients and staff, and educational workshops for staff focusing on education about specific diseases and clinical social work interventions with this population. Respondents also clearly stated the importance of mutual support activities. Because they felt both "just venting" as well as discussing work related problems were very helpful and "meaningful," there was a suggestion that the agency introduce regular, voluntary, staff support groups and reinstate the agency wide retreats that had been discontinued a few years earlier.

Cassel, (1976), pointed out that "it seems more feasible to attempt to improve and strengthen social supports rather than reduce the exposure to stressors" such as those identified in this study. (p. 121). Since Cassel seems to be suggesting that the job dimensions most related to strain may be difficult to alter, it is important to have available other ways within the agency to handle problematic issues. The community wide memorials at the agency are a good example of such a strategy. Agencies would do well to heed Cassel's observation and find ways of allocating time for their staff to participate in mutual support programs. They should also participate with staff in developing support programs. Ultimately, these practices may prove to be the most cost effective.

Recommendations for Social Work Research

The study found that while the participants described situations which they referred to as "stressful" and spoke of feeling "burned out", they also demonstrated resilience in the face of clients' physical pain, suffering, and death. There were comments that directly or indirectly indicated they derived significant satisfaction from their work. It appears that this sense of fulfillment and accomplishment served as an important coping resource for the mental health professionals in this study. Goodman (1990) observed a similar phenomenon in her study of the social workers caring for terminally ill patients in an acute care hospital. So did Dillon (1990) and Levine (1997) in their discussions of stress in health care social work roles.

Current research on stress, job satisfaction, and burnout has suggested many correlates that buffer occupational strains. These range from organizational variables like financial rewards and promotion opportunities, tǫ social support and a feeling of accomplishment that comes from practice mastery and a sense of competence. However, because the indicators for burnout and job satisfaction have been contradictory at times, it is possible that current predictive models are functional but incomplete (Jayaratne and Chess, 1983). It remains unclear just how and why the satisfactions and sense of meaning expressed by this staff worked so well since these constructs have not been studied in the stress literature. The inclusion of predictive variables that reflect purpose and meaning should be part of a systematic study of burnout and job satisfaction.

Goodman offered one avenue of inquiry when she remarked that the participants in her study were able to cope with organizational frustrations they faced. She suggested that "this success...sustained them in the face of their general frustration with their position in the hospital hierarchy" (p236). She later speculated that this response might be the result of a "professional congruence" with supportive interventions that are a part of social work practice (p. 257). It would be interesting and constructive to study what role professional values and principles play in coping with the work related frustrations inherent in social work practice, especially in high stress settings and particularly at a time when social work's usefulness is being challenged in the current healthcare climate.

Since this study was based on a convenience sample within a single agency, it does not allow for broad generalizations or hypothesis testing. The findings are only suggestive. However they do raise a number of questions, in terms of education, practice, research, and policy that warrant further investigation.

Conclusion

This chapter summarized the major findings of a qualitative research study of the experiences of a group of mental health professionals. The study focused on defining the stress of working with chronically mentally ill clients who simultaneously have either acute or chronic physical illnesses or are dying from them. It also focused on understanding how these professionals coped with this work. Because the study relied on focus groups to obtain data, findings were presented in participants' own words to describe their practice behaviors and personal feelings, as well as their professional opinions and values.

Ultimately, this study established that a combined approach to addressing the multifaceted problem of physical illness among the mentally ill is sorely needed. Together, social work education, research and organizational interventions would be more productive than any single attempt to address worker burnout, retention, job satisfaction and, most importantly, client care.

Appendix 1

Introductory Letter Requesting Permission to Meet With Agency Staff to Discuss The Research Project

Dear

My name is Phyllis Mervis. I am a Doctoral candidate at the Hunter College School of Social Work. This letter is to introduce myself and to request your assistance in my doctoral research.

I worked on the Oncology Service as a medical social worker and supervisor at Mount Sinai Hospital for 20 years. For the past 15 years I have been in private practice where I see adults in individual and group modalities.

In addition to my private practice, I am an Adjunct Clinical Instructor at Mount Sinai Medical School in the Department of Community Medicine/Social Work and in the Department of Psychiatry where I also hold the title of Senior Supervisor in the Division of Group Psychotherapy. I currently serve as Chairperson of the Group Psychotherapy Practice Committee of the New York State Society of Clinical Social Workers. For the past four years I have held the title of Workshop Co-Chairperson of the American Group Psychotherapy Association's (AGPA) Annual Conference Committee. I was recently invited to chair AGPA's Special Interest Group on Group Treatment of the Medically Ill.

My dissertation project is an exploratory study to identify the experience of mental health professionals whose chronically mentally ill clients now have developed co-occurring physical illnesses. Some of these clients are dying. The project will include an introductory meeting with staff, followed by a pre-group demographic questionnaire of attitudes and a one and one half-hour focus group meeting with those staff who are interested in and consent to participating in the project.

Participation in the group will be strictly confidential. I will be using codes, not names, for staff participants and agencies will not be identified in any publications or oral presentations. As an experienced social worker, I do not anticipate any problems, but should any staff want counseling after the study, I will be providing both a list of colleagues who do work in the area of workplace stress and several references on the topic.

This project has been accepted by my Dissertation Committee at the Hunter School of Social Work and has been approved by the Institutional Review Board of City University of New York.

At the present time the literature makes slight reference to co-occurring physical illnesses of clients and no mention of their impact on the staff. I hope you will agree to let me meet with your staff for the purposes of undertaking this important area of study.

I will telephone you next week to discuss your decision and any questions or comments you may have regarding this project.

Thank You,

Phyllis Mervis MSW, CSW

Appendix 2

Staff Information Letter Regarding The Research Project and Consent Form

My name is Phyllis Mervis. I am a doctoral candidate at Hunter College School of Social Work. I am writing to invite you to take part in a social work research study.

My dissertation project is an exploratory study to identify the experience of mental health professionals whose chronically mentally ill clients now have co-occurring physical illnesses and/or are dying. The project will include an introductory meeting followed by a pregroup demographic questionnaire of attitudes and a one and one half hour (1 1/2) focus group meeting with those staff who are interested in and consent to participating in the project. The focus group will meet at a convenient time designated by you.

Participation in this study is completely confidential. Codes, not names, will be used and I will not discuss specific group content with anyone at your agency. Participation will not affect your employment in any way. Also, the agency will not be revealed in any publications or oral presentations of this study's results. All tapes and transcripts will be kept in my locked files. Since you will be expected to talk as freely as you can about work related feelings/reactions, confidentiality about the group content needs to be honored by everyone in order to ensure safety. Also, I will work to minimize any discomfort in the form of anxiety or embarrassment. Should you feel the need of any counseling as a result of participation, I will be providing both a list of references about workplace stress and a list of colleagues of mine familiar with this subject who will be available for consultation. Also, you may decide at any time that you do not wish to continue.

If you are interested in participating in this study, I will be at your agency on ____________ at_____ for a pre-group orientation meeting. At that time I will answer any questions or concerns about the goals of the study and the group procedures. Should you then decide to participate in the study, your attendance in the focus group will serve as affirmation of your voluntary consent to participation in this research. Study results and a summary of the research will be available at the completion of the project.

If you have any questions at any time, feel free to call me at my office. The phone number there is 369-8879. You can also contact my faculty advisor, Dr. Irwin Epstein, at (212) 452-7030.

Thank you for your consideration and cooperation.

Phyllis Mervis, MSW, CSW

Name________________________

Social Security #_______________
(last 4 numbers)

Date__________________

Appendix 3

Participant Questionnaire

1. Code (last 4 digits of S.S. #_____
2. Age at last birthday________
3. Education:
   Completed High School_____ Completed College_____

   Some Graduate Work_____ Advanced Degree_____Date_____
4. How many years have you been employed at this agency_____
5. What is your job title?____________
6. Are you an MSW_____ CSW_____ BSW_____ PhD_____
   RN_____ BA_____ Other_____
7. How many years have you worked with chronically mentally ill patients? _____
8. Over the years, what proportion of these patients have also been seriously medically ill?_________
9. What proportion of your current caseload is seriously medically ill?_________
10. Would you prefer to work only with chronically mentally ill clients who are not medically ill? Yes______No______

    Please give your reasons. ____

    ____

    ____

    ____
11. Would you prefer to work only with seriously medically ill clients who are not chronically mentally ill? Yes______No______

11 (cont'd.)
Please give your reasons.______________________________

____

12. Would you prefer to work with clients who are chronically mentally ill *and* medically ill? Yes ___ No ___

Please give your reasons. ______________________________

____

____

13. Would you prefer a different patient population? Please give your reasons.

____

____

____

14. If you have no preference, please give your reasons.

____

____

____

15. How would you describe the stressfulness of your work with clients who are chronically mentally ill and also seriously medically ill as compared to your work with those clients who are *only* chronically mentally ill? (Check one)

Extremely more stressful	Moderately more stressful	Slightly more stressful	No difference in stress level
1	2	3	4

16. How well do you feel you are currently coping with the stresses of your work?

Extremely Well	Moderately Well	Mildly Well	Neither Well Nor Poorly	Mildly Poorly	Moderately Poorly	Extremely Poorly
1	2	3	4	5	6	7

17. Do you feel knowledgeable about the psychosocial issues of chronic mental illness? Circle one.

Very knowledgeable	Moderately knowledgeable	Slightly knowledgeable	Not at all knowledgeable
1	2	3	4

18. Do you feel knowledgeable about the psychosocial issues of serious medical illness? Circle one.

Very knowledgeable	Moderately knowledgeable	Slightly knowledgeable	Not at all knowledgeable
1	2	3	4

19. Please describe issues you feel would be important to cover in a professional support group.

Appendix 4
Resource List for Participants

References

Davidson, K. and Z. Foster. (1995). "Social Work with Dying and Bereaved Clients: Helping the Workers." Social Work In Health Care. 2:4. 1-6.

Donovan, R. (1987). "Stress in the Workplace: A Framework for Research and Practice." Social Casework. 68:5. 259-266.

Grossman, A. and C. Silverstein. (1993). "Facilitating Support Groups for Professionals Working with People with AIDS." Social Work. 38:2. 144-151.

Jones, F. B. C. Fletcher, and K. Ibbetson. (1991). "Stressors and Strains Amongst Social Workers: Demands, Supports, Constraints, and Psychological Health." British Journal of Social Work. 21:5. 443-469.

Lederberg, M. (1992). "Group Support for Medical Staff in High-Stress Settings." In Eds. Alonso and Swiller. Group Psychotherapy In Clinical Practice, Washington, D.C. American Psychiatric Association Press. 171-184.

Scully, R. (1983). "The Work-Setting Support Group: A Means of Preventing Burnout." In Ed. B. Farber. Stress and Burnout in the Human Service Professions. New York. Pergamon Press.

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Appendix 5
Interview Guide

1. What led you to work with chronically mentally ill clients?

   Probe: planned, prefer, family history

2. The literature on social work in physical health settings describes it as very stressful. Is this true for you and if so what are the difficulties in your work with your clients who now have co-occurring illnesses?

   Probe: client related, knowledge related, role related, agency related

3. In what ways (how) is working with clients who are also medically ill different from the work you do with clients who only have psychiatric disabilities?

   Probe: relationships, responsibilities, knowledge

4. What has been the most difficult aspect of your work with the clients who have co-occurring illnesses?

   Probe: illness related, knowledge related, role related, agency related

5. What have you done to cope with the difficulties of this work?

   Probe: coping strategies, support, religion

6. If you don't think the work with these clients is more stressful, what are the reasons why?

   Probe: previous experience, courses, challenge

7. What do you think it is about you that has helped or hindered you in coping with the work with the clients with co-occurring illnesses?

   Probe: personality, attitudes, colleagues, family

8. What feelings and/or thoughts have you had while doing this work?

9. Are there any problems with the agency or with outside organizations that has added stresses to your work with this client population?

   Probe: workload, staffing, communication problems

10. In what ways do you think the agency could be more helpful to you?

    Probe: staffing, support, recognition, money,

11. How would you describe your relationships with the clients who are also medically ill?

    Probe: longitudinal and lateral issues.

12. Is there a client or situation/incident that particularly stands out as being an example of the difficulties of this work?

13. Have you worked with a client who died or known about a client who died and if so what was that like for you?

    Probe: more or less personal, intense, involved

14. Is there anything else about this work that you would like to add?

Appendix 6
Aggregated Frequency Distribution of Content Codes: Residential Sites

Content Category	n	%
Problems associated with physical illness	194	26.3
Coping strategies and behaviors	123	16.6
Problems associated with mental illness	107	14.5
Bureaucratic and organizational problems	68	9.2
Satisfactions	67	9.1
Reasons for working in mental health	41	5.5
Differences between residential and clinic settings	40	5.4
Expressions of work overload	37	5.0
Expressions of burnout	36	4.9
Attachment to clients	17	2.3
Training	9	1.2
	739	100.0

Appendix 7
Aggregated Frequency Distribution of Content Codes: Continuing Day Treatment

Content Category	n	%
Problems associated with physical illness	137	28.7
Expressions of burnout	84	17.5
Problems associated with mental illness	78	16.3
Satisfactions	52	10.9
Coping strategies and behaviors	49	10.3
Expressions of work overload	43	9.0
Bureaucratic and organizational problems	23	4.8
Suggestions	12	2.5
	478	100.0

Bibliography

Abrahams, R. (1972). "Mutual Help for the Widowed." Social Work. 17(5). 54-61.

Abrams, R. and J. Sweeney. (1982). "A Critique of the Process-Oriented Approach to Ward Staff Meetings." The American Journal of Psychiatry. 139. 769-773.

Acker, G. (1999). "The Impact of Clients' Mental Illness on Social Workers' Job Satisfaction and Burnout." Health and Social Work. 24(2). 112-119.

Alexander, D. (1993). "Staff Support Groups: Do They Support and Are They Even Groups?." Palliative Medicine. 7(2). 127-132.

Arches, J. (1991). "Social Structure, Burnout, and Job Satisfaction." Social Work. 36. 202-206.

Arndt, H. and M. Gruber. (1977). "Helping Families Cope with Acute and Anticipatory Grief." In Eds. E. Pritchard, et al. Social Work with the Dying Patient and the Family. New York. Columbia University Press. 38-48.

Aveline, M. (1993). "Principles of Leadership in Brief Training Groups for Mental Health Care Professionals." International Journal of Group Psychotherapy. 43(1). 107-129.

Babcock, C. (1963). "Inner Stress in Illness and Disability." In Eds. H. Parad and R. Miller. Ego Oriented Casework: Problems and Perspectives. New York. Family Service Association of America.

Bahrey, F., M. McCallum, and W. Piper (1991). "Emergent Themes and Roles in Short-Term Loss Groups." International Journal of Group Psychotherapy. 41(3). 329-345.

Barber, G. (1986). "Correlates of Job Satisfaction Among Human Service Workers." Administration in Social Work. 10(1). 25-38.

Bargal, D. and N. Gutterman. (1997). "Career Outcomes Among Medical vs. Family Service Social Workers in Israel." Social Work in Health Care. 25(1/2). 223-241.

Barrett, C. (1978). "Effectiveness of Widows' Groups in Facilitating Change." Journal of Consulting and Clinical Psychology. 46. 20-31.

Barrett, M.C. and J. Mckelvey. (1980). "Stresses and Strains on the Child Care Worker: Typologies for Assessment." Child Welfare. 59(5). 277-285.

Beck, D.F. (1987). "Counselor Burnout in Family Service Agencies." Social Casework. 68:1. 3-15.

Beemsterboer, J. and Baum, B. (1984). "Burnout: Definitions and Health Care Management." Social Work in Health Care. 10(1). 97-109.

Ben-Sira, Z. (1985). "Potency: A Stress-Buffering Link in the Coping, Stress, Disease Relationship." Social Science Medicine. 21(4). 397-406.

Berkman, B. (1996). "The Emerging Health Care World: Implications for Social Work Practice and Education." Social Work. 41(5). 541-555.

Berman-Rossi, T. (1993). "The Tasks and Skills of the Social Worker Across Stages of Group Development." Social Work with Groups. 16(1/2). 69-81.

Billings, A. and R. Moos. (1981). "The Role of Coping Responses in Attenuating the Impact of Stressful Life Events." Journal of Behavioral Medicine. 4. 139-157.

Billingsley, A., N. Streshinsky, and V. Gurgin. (1966). Social Work Practice in Child Protective Practice Services. Berkeley. University of California School of Social Welfare. 53.

Blankertz, L.E. and S.E. Robinson. (1997). "Recruitment and Retention of Psychosocial Rehabilitation Workers." Administration and Policy in Social Work. 24(3). 221-234.

Blum, D. (1993). "Social Work Services for Adult Cancer Patients and Their Families." In N. Stearns, M. Lauria, J. Hermann, and P. Fogelberg. Eds. Oncology Social Work: A Clinician's Guide. Atlanta, Georgis, American Cancer Society. 101-136.

Bogden, R.C. and Biklen, S.K. (1982). Qualitative Research for Education: An Introduction to Theory and Methods. Boston: Allyn and Bacon.

Bolger, N. Zuckerman, A. and Kessler, R. (2000). "Invisible Support and Adjustment to Stress." Journal of Personality and Social Behavior. 79(6). 953-961.

Brabender, V. (1993). "A Study of the Curative Factors in Short Term Group Therapy." Hospital and Community Psychiatry. 34. 643-654.

Brauer, S. (1990). "The HIV Infected Individual: Group Work as a Rite of Passage." Smith College Studies in Social Work. 60(3). 233-243.

Breton, M. (1989). "Learning From Social Group Work Traditions." Proceedings, Eleventh Annual Symposium on Social Work with Groups. Montreal Canada.

Brickner, P., T. Filardo, M. Iseman, R. Green, B. Conanen, and A. Elny (1984). Ed. H. R. Lamb. "Medical Aspects Of Homelessness." In The Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association. Washington, D.C. American Psychiatric Association..243-259.

Bronstone, A. (1993). "Mutual Support Groups as a Social Support Intervention: Mechanisms of Change and Their Relation to Mental Health." (Doctoral Dissertation, Yale University). Dissertation Abstracts International #9415847.

Brown, G.W. and T. Harris. (1978). Social Origins of Depression. New York. The Free Press.

Brown, L. (1984). "Mutual Help Staff Groups to Manage Work Stress." Social Work with Groups. 7(2). 55-66.

Brown, L. (1991). Groups for Growth and Change. New York. Longman Publishing Group.

Budman, S. and M. Gold. (1988). Theory and Practice of Brief Therapy. New York. Guilford Press.

Budman, S. Et Al. (1984) "The Effects of Time-Limited Group Psychotherapy: A Controlled Study." International Journal of Group Psychotherapy. 43(4). 587-603.

Campbell, D.T. and Stanley, J.C. (1963). Experimental and Quasi-Experimental Designs for Research. Chicago: Rand McNally.

Caplan, G. (1981). "Mastery of Stress: Psychosocial Aspects." The American Journal of Psychiatry. 138:4. 413-420.

Carrilio, T. and D. Eisenberg. (1984). "Using Peer Support to Prevent Worker Burnout." Social Work. 65. 307-310.

Cassel, J. (1976). "The Contribution of the Social Environment to Host Resistance." American Journal of Epidemiology. 104. 107-123.

Cherniss, C. (1980). Staff Burnout: Job Stress in the Human Services. Beverly Hills, California. Sage Publications.

Cherniss, C. and E. Egnatios (1978). "Is There Job Satisfaction in Community Mental Health?" Community Mental Health Journal. 14(4). 309-318.

Cobb, S. (1976). "Social Support as a Moderator of Life Stress." Psychosomatic Medicine. 38. 300-314.

Cohen, B. (1994). "The Process Group in Institutional Settings: Special Techniques for an Endangered Species." International Journal of Group Psychotherapy. 44(3). 333-348.

Cohen, S. and T. Wills (1985). "Stress, Social Support and the Buffering Hypothesis." Psychological Bulletin, 98. 310-357.

Collins, A. and J. Grobman. (1989). "Group Methods in the General Hospital." In Eds. Kaplan, H. and B. Saddock. Comprehensive Group Psychotherapy (2nd Ed.). Baltimore, M.D. Williams and Wilkins. 289-293.

Corcoran, K. and A. Bryce. (1984). "Intervention in the Experience of Burnout: Effects of Skill Development." Journal of Social Service Research. 7(1). 71-79.

Counselman, E., R.L. Weber and J.A. Lazarus (1994). "Leadership of Mental Health Consultation Groups: A Model for Group Therapists." International Journal of Group Psychotherapy. 44(3). 349-360.

Courage, M. and D. Williams. (1987). "An Approach to the Study of Burnout In Professional Care Providers in Human Service Organizations." In Burnout Among Social Workers. New York. The Haworth Press. 7-21.

Coyle, G. (1930). Group Work with American Youth. New York. Harper.

Coyne, J.C. and R.S. Lazarus. (1980). "Cognitive Style, Stress Perception, and Coping." In Lutash, I.L. and L.B. Schlesinger. Eds. Handbook on Stress and Anxiety: Contemporary Knowledge, Theory, and Treatment. San Francisco, Jossey-Bass. 144-158.

Davidson, K. (1983) Development of a Support Program for Social Workers Serving Cancer Patients. Unpublished Doctoral Dissertation. City University of New York.

Davidson, K. (1985). "Social Work with Cancer Patients: Stresses and Coping Patterns." Social Work in Health Care. 10(4). 73-82.

Davidson, K. and Z. Foster. (1995). "Social Work with Dying and Bereaved Clients: Helping the Workers." Social Work in Health Care. 21(4). 1-16.

DeLongis, A. J.C. Coyne, G. Dakof, S. Folkman, and R.S. Lazarus. (1982). "Relationship of Daily Hassels, Uplifts, and Major Events to Health Status." Health Psychology. 1. 119-136.

Dillon, C. (1990). "Managing Stress in Health Social Work Roles Today." Social Work in Health Care. 14(4). 91-108.

Donovan, R. (1987). "Stress in the Workplace: A Framework for Research and Practice." Social Casework. 68(5). 259-256.

Eckenrode, J. (1984). "Impact of Chronic and Acute Stressors on Daily Reports of Mood." Journal of Personality and Social Psychology. 46. 907-918.

Edelwich, J. and A. Brodsky (1983). Burnout: Stages of Disillusionment in the Helping Professions. New York. Pergamon Press.

Egan, M. (1993). "Resilience at the Front Lines: Hospital Social Work with AIDS Patients and Burnout." Social Work in Health Care. 18(2). 109-125.

Epstein, I. (1993). "Promoting Reflective Social Work Practice: Research Strategies and Consulting Principles." Unpublished paper presented at the Center for the Study of Social Work Practice Conference, Columbia University, New York City.

Evans, P. and N. Bracht. (1971). "Meeting Social Work's Challenge In Community Mental Health." Mental Hygiene.55. 295-297.

Falk, H. (1995). "Central Characteristics of Social Work with Groups: A Sociocultural Analysis." In Eds. R. Salmon and R. Kurland. Group Work Practice in a Troubled Society: Problems and Opportunities. New York. Haworth Press. 63-72.

Farber, B. and L. Heifetz (1982). "The Process and Dimensions of Burnout in Psychotherapists." Professional Psychology. 13(2). 293-301.

Fleishman, J. (1984). "Personality Characteristics and Coping Patterns." Journal of Health and Social Behavior. 25(June):229-244.

Folkman, S. (1984). "Personal Control and Stress and Coping Processes: A Theoretical Analysis." Journal of Personality and Social Psychology. 46:4. 839-852.

Folkman, S. and R.S. Lazarus. (1980). "An Analysis of Coping Behavior in a Middle-Aged Community Sample." Journal of Health and Social Behavior. 21. 219-239.

Foster, Z. and K. Davidson (1995). "Satisfactions and Stresses for the Social Worker." In Eds. Corlen, Germino, Pittman, and Lander. A Challenge for Living: Dying, Death, and Bereavement. Boston, Jones and Bartlett. 285-300.

Fox, R.C. (1980). "The Human Condition of Health Professionals." Distinguished Lecture Series. School of Health Studies, University of New Hampshire. Durham, New Hampshire, University of New Hampshire. 11-39.

Freud, S. (1913). "Totem and Taboo." In Standard Edition of the Complete Psychological Works of Sigmund Freud. London. Hogarth Press.

Freud. S. (1917). Mourning and Melancholia. London. Hogarth.

Freudenberger. H. (1974). "Staff Burnout." Journal of Social Issues. 30:1. 159-175.

Fulton, R. (1979). "Anticipatory Grief, Stress, and the Surrogate Griever." In J. Tache, et. al. Eds. Cancer, Stress, and Death. New York. Plenum Press. 87-93.

Fuhrman, E. (1974). A Child's Parent Dies: Studies in Childhood Bereavement. New Haven. Yale University Press.

Galinsky, M. and J. Schopler. (1994). "Negative Experiences in Support Groups." Social Work in Health Care. 20(1).77-95.

Garland, J, H. Jones, and R. Kolodney. (1973). Ed. S. Bernstein. "A Model for Stages of Development in Social Work Groups." In Explorations in Group Work. Boston. Milford House, Inc.

Garside, B. (1993). "Physicians Mutual Aid Group: A Response To Aids-Related Burnout." Health and Social Work. 18(4). 259-267.

Gersten, J.C., T.S. Langner, J.G. Eisenberg, and O. Simcha-Fagan. (1977). "An Evluation of the Etiologic Role of Stressful Life-Change Events in Psychological Disorders." Journal of Health and Social Behavior. 18. 228-244.

Gilbar, O. (1998). "Relationship Between Burnout and Sense of Coherence in Health Social Workers." Social Work in Health Care. 26(3). 39-49.

Gibelman, M. and P. Schervish. (1997). "Areas of Practice of Social Workers in Mental Health. Psychiatric Services. 48(12). 1509.

Glaser, B. and Strauss, A. (1967). The Discovery of Grounded Theory. New York: Aldine de Gruyter.

Glassman, U. (1991). "The Social Work Group and Its Distinct Healing Qualities in the Health Care Setting." Health and Social Work. 16(3). 203-212.

Gleichner, H.B. Et Al. (1990). Ed. P. Brickner, et al. "Staff Organization, Retention, and Burnout." In Under the Safety Net: The Health and Social Welfare of the Homeless in the United States. New York. W.W. Norton & Company. 275-283.

Glob, W., D. Narducci, J. Frohock and S. Friedman. (1993). Ed.S Katz, D. Nardacci, and A. Sabatini. "Interdisciplinary Strategies for Engagement and Rehabilitation." In Intensive Treatment of the Homeless Mentally Ill. American Psychiatric Press. Washington, D.C. 107-128.

Goodman, H. (1990). Death Work: Staff Perspectives on the Care of Terminally Ill Patients In An Acute Care Hospital. Unpublished doctoral dissertation. City University of New York, New York.

Goldmeir, J. (1976). "Short-Term Models in Long-Term Treatment." Social Work. 350-355.

Greene. R. (1986). "Countertransference Issues in Social Work With the Aged." Journal of Gerontological Social Work. 9(3) 79-88.

Grossman, A. and C. Silverstein. (1993). "Facilitating Support Groups for Professionals Working with People with AIDS." Social Work. 38(2). 144-151.

Hamburg, D. and J. Adams. (1967). "A Perspective on Coping Behavior: Seeking and Utilizing Information in Major Transitions." Archives of General Psychiatry. 17. 277-284.

Haran, J. (1988). "Use of Group Work to Help Children Cope with the Violent Death of a Classmate." Social Work with Groups. 11(3). 79-92.

Harrington, D., N. Bean, D. Pintello, D. Mathews. (2001). "Job Satisfaction and Burnout: Predictors of Intentions to Leave a Job in a Military Setting." Administration in Social Work. 25(3) 1-16.

Harrison, W. D. (1980). "Role Strain and Burnout in Child Protective Service Workers." Social Service Review. 54. 31-43.

Harrison. W. D. (1983). Ed. Farber. "A Social Competence Model of Burnout." In Stress and Burnout In the Human Services. New York. Pergamon Press. 29-39.

Hartford, M. (1971) Groups in Social Work. New York. Columbia University Press.

Hedges, A. (1985). Ed. R. Walker. "Group Interviewing." In Applied Qualitative Research. Gowere Publishing Co. Limited. England. 70-91.

Henry, S. (1981). Group Skills in Social Work: A Four-Dimensional Approach. Illasca, Illinois. Peacock.

Himle, D., S. Jayaratne, P. Thyness. (1989). "The Effects of Emotional Support on Burnout, Work Stress and Mental Health Among Norwegian and American Social Workers." Journal of Social Service Research. 13(1) 27-45.

Himle, D. and S. Jayaratne. (1990). "Burnout and Job Satisfaction: Their Relationship to Perceived Competence and Work Stress Among Undergraduate and Graduate Social Workers." Journal of Sociology and Social Welfare. 17(4) 93-108.

Himle, D., S. Jayaratne, and W. Chess. (1991). "Buffering Effects of Four Social Support Types on Burnout Among Social Workers." Social Work Research and Abstracts. 27(1). 21-27.

Holmes, T.H. and R.H. Rahe. (1967). "The Social Readjustment Scale." Journal of Psychosomatic Research. 11. 213-218.

House, J. (1981). Work Stress and Social Support. Reading, Mass. Addison-Wesley Publishing.

Hover, D. (1986). "Development of a Hospice Staff Support Group." The American Journal of Hospice Care. 39-41.

Isaac, R. and V. Armat (1990). Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill. New York. The Free Press.

Jayaratne, S. (1993). "The Antecedents, Consequences, and Correlates of Job Satisfaction." In R.T. Golembiewski. Ed. Handbook of Organizational Behavior. New York. Marcel Dekker.

Jayaratne, S. and W. Chess. (1983). Ed. B. Farber. "Job Satisfaction and Burnout in Social Work." In Stress and Burnout in the Human Service Professions. Pergamon Press. New York. 129-141.

Jayaratne, S. and W. Chess. (1983). "Job Satisfaction and Turnover Among Social Work Administrators: A National Survey," Administration in Social Work. 7 (Summer). 11-22.

Jayaratne, S., T. Tripodi, and W. Chess. (1983). "Perceptions of Stress and Strain by Male and Female Social Workers." Social Work Research and Abstracts. 19. 19-28.

Jayaratne, S. and W. Chess. (1984). "The Effects of Emotional Support on Perceived Job Stress and Strain." The Journal of Applied Behavioral Science. 20(2). 141-153.

Jayaratne, S. and W. Chess. (1986). "Job Stress, Job Deficit, Emotional Support and Competence: Their Relationship to Burnout." Journal of Applied Social Sciences. 10(2). 135-155.

Jayaratne, S., D. Himle, and W. Chess. (1988). "Dealing with Work Stress and Strain: Is the Perception of Support More Important Than Its Use?." The Journal of Applied Behavioral Science. 24(2). 191-202.

Johnson, A. B. (1990). Out of Bedlam: The Truth About Deinstitutionalization. Basic Books. New York.

Johnston, M. and G. Stone. (1987). "Social Workers and Burnout: A Psychological Description." In Ed. D. Gillespie. Burnout Among Social Workers. New York. The Haworth Press. 81-90.

Jones, D. (1979). "The Grief Therapy Project: The Effects of Group Therapy with Bereaved Surviving Spouses on Successful Coping with Grief." (Doctoral Dissertation, University of Southern California). Dissertation Abstracts International, 39, 6121A-6122B.

Jones, F., B.C. Petcher, and K.Ibbetson. (1991). "Stressors and Strains Amongst Social Workers: Demands, Supports, Constraints, and Psychological Health." British Journal of Social Work. 21(5). 443-469.

Kadushin, A. (1974). Child Welfare Services. New York. Macmillan. 701.

Kadushin, G. and M. Egan. (1997). "Educating Students for a Changing Health Care Environment: An Examination of Health Care Practice Course Content." Health and Social Work. 22(3). 211-222.

Kanas, N. (1986). "Support Groups for Mental Health Staff and Trainees", International Journal of Group Psychotherapy. 36(2). 279-295.

Kane, R. (1975). "The Interprofessional Team As a Small Group." Social Work In Health Care. 1. 19-32.

Kanner, A.D., J.C. Coyne, C. Schaefer, and R.S. Lazarus. (1981). "Comparisons of Two Modes of Stress Measurement: Daily Hassels and Uplifts vs. Major Life Events." Journal of Behavioral Medicine. 4. 1-39.

Kastenbaum, R. (1969). "Death and Bereavement in Later Life." In Ed. A. Kutcher. Death and Bereavement. Springfield, Illinois, Charles C. Thomas.

Klein, R. (1985). "Some Principles of Short-Term Group Therapy." International Journal of Group Psychotherapy. 35(3). 307-330.

Kobasa, S. C. (1979). "Stressful Life Events, Personality, and Health: An Inquiry Into Hardiness." Journal of Personality and Social Psychology. 37(1). 1-11.

Kobasa, S. C. (1982). "Hardiness and Health: A Prospective Study." Journal of Personality and Social Psychology. 42(2). 168-177

Koeske, G. and R. Koeske. (1989). "Work Load Burnout: Can Social Support and Perceived Accomplishment Help?" Social Work. 43(3). 243-248.

Koocher, G. (1979). "Adjustment and Coping Among the Caretakers of Cancer Patients." Social Work in Health Care. 5(2). 145-150.

Kropotkin, P. (1916). Mutual Aid: A Factor of Evolution. New York, Knopf.

Kurland, R. "A Model of Planning for Social Work with Groups." Unpublished.

Kurland, R. (1978). "Planning: The Neglected Component of Group Development." Social Work with Groups. 1(2). 173-178.

Kuland, R. and R. Salmon. (1992). "Groupwork vs. Casework in a Group: Principles and Implications for Teaching and Practice." Social Work with Groups. 15(4). 3-14.

Lamb, H. R. (1984). Ed. R. Lamb. "Deinstitutionalization and the Homeless Mentally Ill." In The Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association. Washington, D.C. American Psychiatric Association. Pp. 55-74.

Landerman, R., L.K. George, R.T. Campbell, and D.G. Blazer. (1989). "Alternative Models to the Stress Buffering Hypothesis." American Journal of Community Psychology. 17:5. 625-644.

Lang, E., D.A. Halperin, and H. Swiller. (1986). Ed. D. Halperin. "Process Groups for the Training of Psychiatrists." Ed. D.Halperin. In Group Psychodynamics. Chicago, Yearbook Publishers. 209-225.

LaRocco, J. House, and J. French (1980). "Social Support, Occupational Stress, and Health." Journal of Health and Social Behavior, 21. 202-218.

Larson, D. (1986). "Developing Effective Hospice Staff Support Groups: Pilot Test of an Innovative Program." The Hospice Journal. 2. 41-55.

Lawrence, L. (1992). 'Till Death Do Us Part: The Application of Object Relations Theory to Facilitate Mourning in a Young Widows' Group." Social Work in Health Care. 16(3). 67-81.

Lazarus, R.S. (1981). "The Stress and Coping Paradigm." In Eisdorfer, C., D. Cohen, A. Kleinman, and P. Maxim. Eds. Models for Clinical Psychopathology. New York. Academic Press. 177-214.

Lazarus, R. S. and S. Folkman (1984). Stress, Appraisal, and Coping. New York. Springer Publishing Company.

LeCroy, C. and M. Rank. (1987). "Factors Associated with Burnout in the Social Services: An Exploratory Study." In Burnout Among Social Workers. 30-40.

Lederberg, M. (1992). "Group Support for Medical Staff in High-Stress Settings." In Eds. Alonso and Swiller. Group Psychotherapy In Clinical Practice, Washington, D.C. American Psychiatric Association Press. 171-184.

Lederberg, M. (1982). "Stresses on Cancer Staff: The Uses of Group to Mitigate Them." In. Ed. J. Holland. Current Concepts in Psychosocial Oncology. New York. Oxford University Press. 631-645.

Lefton, M. and W.R. Rosengren. (1974). Eds. Y. Hasenfeld and R. English. "Organizations and Clients: Lateral and Longitudinal Dimensions." In Human Service Organizations: A Book of Readings. Ann Arbor. The University of Michigan Press. 472-485.

Levine, J. (1997). Conflicted Helping: The Mediator Role of Social Work Discharge Planning in a Rapidly Changing Health Care Environment. Unpublished doctoral dissertation. City University of New York. New York.

Lewis, H. (1980). "The Battered Helper." Child Welfare. 59(4). 195-201.

Liberman, M. and I. Yalom. (1992). "Brief Group Psychotherapy for the Spousally Bereaved: A Controlled Study." International Journal of Group Psychotherapy. 42(1). 117-132.

Liberman, M. and L. Videka-Sherman. (1986). "The Impact of Self-Help Groups on the Mental Health of Widows and Widowers." American Journal of Orthopsychiatry. 56. 435-439.

Lief, H. and R. Fox. (1963). Eds. Lief, et. al. "Training for 'Detached Concern' in Medical Students." In The Psychological Basis of Medical Practice. New York. Harper and Row. 12-34.

Lincoln, Y.S. and Guba, E.G. (1985). Naturalistic Inquiry. Beverly Hills, CA: Sage.

Lindemann, E. (1944). "Symptomatology and Management of Acute Grief." American Journal of Psychiatry. 101. 141-148.

Liu, F. (1995). "Towards Mutual Aid in Groups." In Group Work Practice in a Troubled Society.

Lofland, J. and Lofland, J. (1971). Analyzing Social Settings: A Guide to Qualitative Observation and Analysis. Belmont, Ca. Wadsworth Publishing Company.

Mailick, M. (1991). "Recruitment and Retention of MSW Graduates. Editorial. Social Work in Health Care. 16(2). 1-4.

Mallinckrodt, B. (1989). "Social Support and the Effectiveness of Group Therapy." Journal of Counseling Psychology. 36(2). 170-175.

Marmar, C. Et Al. (1988). "A Controlled Trial of Brief Psychotherapy and Mutual-Help Group Treatment of Conjugal Bereavement." American Journal of Psychiatry. 145. 203-209.

Maslach, C. and S.E. Jackson. (1986). Maslach Burnout Inventory (2nd Ed.). Palo Alto, California. Consulting Psychology Press.

McBroom, E. (1976). "Socialization Through Small Groups." In Eds. R. Roberts and H. Northern. Theories of Social Work with Groups. New York, Columbia University Press.

McCallum, M. and W. Piper. (1990). "A Controlled Study of Effectiveness and Patient Suitability for Short-Term Group Psychotherapy." International Journal of Group Psychotherapy. 40(4). 431-452.

McCallum, M. Et Al. (1993). "Affect and Outcome in Short-Term Therapy for Loss." International Journal of Group Psychotherapy. 43(3). 303-320.

McLean, J. and T. Andrew. (2000). "Commitment, Satisfaction, Stress and Control Among Social Service Managers and Social Workers in the UK." Administration in Social Work. 23:3/4. 93-117.

McCreath, J. (1984). "The New Generation of Chronic Psychiatric Patients." Social Work. 29(5). 436-441.

McCue, J. (1982). "The Effects of Stress on Physicians and Their Medical Practice." The New England Journal Of Medicine. 306(8). 458-463.

Menaghan, E. and E. Merves. (1984). "Coping with Occupational Problems: The Limits of Individual Efforts." Journal of Health and Social Behavior. 25. 406-423.

Meyerson, A.T. (1978). Ed. J.A. Talbott. "What Are the Barriers or Obstacles to Treatment and Care of the Chronically Disabled Mentally Ill?" In The Chronic Mental Patient. Washington, D.C. American Psychiatric Association. 129-136.

Miles, M. and Huberman, A.M. (1994). Qualitative Data Analysis, Second Edition. Thousand Oaks, California. Sage Publications.

Minkoff, K. and R. Stern (1985). "Paradoxes Faced by Residents Being Trained in the Psychosocial Treatment of People with Chronic Schizophrenia." Hospital and Community Psychiatry. 36(8). 859-864.

Mizrahi, T. (1986). Getting Rid of Patients: Contradictions in the Socialization of Physicians. New Brunswick, New Jersey. Rutgers University.

Monat, A. and R.S. Lazarus. (1991). Stress and Coping: An Anthology. New York. Columbia University Press.

Monroe, S.M. (1983). "Major and Minor Life Events as Predictors of Psychological Stress: Further Issues and Findings." Journal of Behavioral Medicine. 6. 189-205.

Mor, V. and L. Laliberte (1984). "Burnout Among Hospice Staff." Health and Social Work. 9(4). 274-283.

Morgan, D. W. (1988). Focus Groups as Qualitative Research. Sage Publications. Newbury Park, California.

Moynihan, R.T. and E. Outlaw. (1984). "Nursing Support Groups in a Cancer Center." Journal of Psychosocial Oncology. 2. 33-47.

Mueller, D.P. (1979). "Social Networks: A Promising Direction for Research on the Relationship of the Social Environment to Psychiatric Disorder." Social Science and Medicine. 14. 147-161.

Northern, H. (1988). Social Work with Groups. (2nd Edition). New York. Columbia University Press.

Norvell, N. Et Al. (1987). "Worksite Stress Management for Medical Care Personnel: Results from a Pilot Program." The Journal for Specialists in Group Work. 118-126.

Ogle, M.E. (1983). "Stages of Burnout Among Oncology Nurses in the Hospital Setting.Oncology Nursing Forum. 10(1) 31-34.

O'Hare. T. (1997). "The Interest of Trainees in Working with Seriously Mentally Ill Persons." Administration and Policy in Mental Health. 24(3) 235-242.

Papadatou, D. (2000). "A Proposed Model of Health Professionals Grieving Process." Omega. 41(1). 59-76.

Pappel, C. and B. Rothman. (1980). "Relating the Mainstream Model of Social Work with Groups to Group Psychotherapy and the Structural Group Approach." Social Work with Groups. 3/2. 5-23.

Parry, J. and J. Tanner. (1995). "Debriefing Groups for Nurses." In Eds. R. Salmon and R. Kurland. Group Work Practice in a Troubled Society: Problems and Opportunities. New York. Haworth Press. 157-164.

Patton, M. (1990). Qualitative Research and Evaluation Methods. Newbury Park, California, Sage Publications.

Pearlin, L.I. (1980). "Life Strains and Psychological Distress Among Adults." In Smelser, N.J. and E.H. Erikson. Eds. Themes of Love and Work in Adulthood. Cambridge. Harvard University Press. 174-192.

Pearlin, L.I. and C. Schooler. (1978). "The Structure of Coping." Journal of Health and Social Behavior. 19. 2-21.

Penn, M., J. Romano, and D. Foat. (1988). "The Relationship Between Job Satisfaction and Burnout: A Study of Human Service Professionals." Administration in Mental Health. 15(3). 157-165.

Pines, A. and D. Kafry. (1981). Burnout: From Tedium to Personal Growth. New York, Free Press.

Pines, and C. Maslach (1978). "Characteristics of Staff Burnout in Mental Health Settings." Hospital and Community Psychiatry. 29(4). 233-237.

Poey, K. (1985). "Guidelines for the Practice of Brief, Dynamic Group Therapy." International Journal of Group Psychotherapy. 35(3). 331-354.

Poulin, J. and C. Walter. (1993). "Burnout in Gerontological Social Work." Social Work. 38:3. 305-316.

Poulin, J. and C. Walter. (1993). "Social Worker Burnout: A Longitudinal Study." Social Work Research and Abstracts. 29:4. 5-11

Price, G. Et Al. (1995) "Group Work With Clients Experiencing Grieving: Moving From Theory to Practice." The Journal for Specialists in Group Work. 20:3. 159-167.

Pryor-Brown and E.L. Cowen. (1989). "Stressful Life Events, Support, and Children's School Adjustment." Journal of Clinical Child Psychology. 18:3. 214-220.

Rainey, L., D. Wellisch, F. Fauzy, D. Wwolcott, and R. Pasnau. (1983). "Training Health Professionals in Psychosocial Aspects of Cancer; A Continuing Education Model." Journal of Psychosocial Oncology. 1(2). 41-60.

Rando, T. (1984) Grief, Dying, and Death: Clinical Interventions for Caregivers. Illinois. Research Press.

Rapp, C. and J. Hanson (1988). "Toward a Model Social Work Curriculum for Practice with the Chronically Mentally Ill." Community Mental Health Journal. 24(4). 270-281.

Ratliff, N. (1988). "Stress and Burnout in the Helping Professions." Social Casework. 69. 147-154.

Reister, A. (1992). "Creating The Adolescent Group Psychotherapy Experience." In Group Psychotherapy In Clinical Practice. 219-236.

Rennie, D., J.R. Phillips, and G.K. Quarto. (1988). "Grounded Theory: A Promising Approach to Conceptualization in Psychology." Canadian Psychology. 29. 139-150.

Ridgely, M. S., J. Morrissey, R. Paulson, H. Goldman, and M. Calloway. (1996). "Characteristics and Activities of Case Managers in the RWJ Foundation Program on Chronic Mental Illness." Psychiatric Services. 47. 737-743. (1996).

Robinson-Kurplus, S. and J. Keim. (1994). "Team Building for Nurses Experiencing Burnout and Poor Morale." The Journal for Specialists in Group Work. 19(3). 155-160.

Rogers, T.F., S. V. Horowitz, and G. Stein. (1995). Evaluation of Short-Term Professional Support Groups. Unpublished Final Report of the HIV Professional Development Project, The New York Academy of Medicine, New York, N.Y.

Ross, E.(1993). "Preventing Burnout Among Social Workers Employed in the Field of AIDS/HIV." Social Work in Health Care. 18(2). 91-107.

Ross, R., E. Altmaier, and D. Russell. 1989). "Job Stress, Social Support, and Burnout Among Counseling Center Staff." Journal of Counseling Psychology. 36(4). 464-470.

Rothenberg, E. (1994). "Bereavement Intervention with Vulnerable Populations: A Case Report on Group Work with the Developmentally Disabled." Social Work with Groups. 17(3). 61-75.

Rutter, M. (1987). "Psychosocial Resilience and Protective Mechanisms." American Journal of Orthopsychiatry. 57(3). 316-331

Ryan, S. (1982). "Childhood Bereavement: Psychological Test Findings of a Post-Death Intervention Program." (Doctoral Dissertation, University of Arizona). Dissertation Abstracts International. 43. 885B.

Sabatini, L. (1988). "Evaluating a Treatment Program for Newly Widowed People." Omega. 19(3). 229-236.

Schopler, J. and Galinsky. (1993). "Support Groups as Open Systems: A Model for Practice and Research." Health and Social Work. 18(3). 195-207.

Schwab, R. (1986). "Support Groups for the Bereaved." The Journal for Specialists in Group Work. 11. 100-106.

Schwartz, W. (1961) "The Social Worker in the Group." In New Perspectives on Services to Groups. New York. National Association of Social Workers.

Schwartz. W. (1977). "Social Group Work: The Interactionist Approach." 17th Edition Encyclopedia of Social Work. 1328-1338.

Scully, R. (1983). "The Work-Setting Support Group: A Means of Preventing Burnout." In Ed. B. Farber. Stress and Burnout in the Human Service Professions. New York. Pergamon Press.

Shernoff, M. (1990). "Why Every Social Worker Should Be Challenged by AIDS." Social Work. 35(2). 5-8.

Shinn, M. and H. Morch. (1983). Ed. B. Farber. "A Tripartite Model of Coping with Burnout." In Stress and Burnout in the Human Service Professions. Pergamon Press. New York. 227-239.

Shinn, M. M. Rosario, H. Morch, and D. E. Chestnut (1984). "Coping with Job Stress and Burnout in the Human Services." Journal of Personality and Social Psychology. 6(4). 864-876.

Sieffert, K., S. Jayaratne, and W. Chess. (1991). "Job Satisfaction, Burnout, and Turnover in Healthcare Social Workers." Health and Social Work. 16. 193-202.

Silverman, P. (1966). "Services for the Widowed During the Period of Bereavement." Social Work Practice. New York. Columbia University Press.

Silverman, P. (1995) "Helping the Bereaved Through Social Support and Mutual Help." In A Challenge for Living: Dying, Death, and Bereavement. Eds. Corlen, Germino, Pittman, and Lander. Boston, Jones and Bartlett.

Simos, B. (1977). "Grief Therapy to Facilitate Healthy Restitution." Social Casework. 337-342.

Skovalt, T. (1974). "The Client as Helper: A Means to Promote Psychological Growth." Counseling Psychologist. 4/3. 58-64.

Smith, G. and C. Cantley. (1985). Ed. R. Walker. "Policy Evaluation: The Use of Varied Data in a Study of a Psychogeriatric Service." In Applied Qualitative Research. Gower Publishing Co. Limited. England. 156-174.

Soricelli, B. and C. Utech. (1985). "Mourning the Death of a Child: The Family and Group Process." Social Work. 30. 429-434.

Stav, A., V. Florian, and E.Z. Shurka. (1987). "Burnout Among Social Workers with Physically Disabled Persons and Bereaved Families." Journal of Social Services Research. 10(1). 81-93.

Stein, E., K. Wade and D. Smith. (1991). "Clinical Support Groups That Work." Journal of AIDS Nursing Care. 2(2). 29-36.

Stewart, David W. and P. Shamdasani. (1994). Focus Groups: Theory and Practice. Newbury Park, Sage Publications.

Strauss, A. and J. Corbin. (1990). Basics of Qualitative Research: Grounded Theory Procedures and Techniques. Newbury Park, California. Sage Publications.

Streepy, J. (1981). "Direct-Service Providers and Burnout." Social Casework. 62. 352-361.

Strupp, H. (1990). "Time-Limited Dynamic Psychotherapy: Development and Implementation of a Training Program." In Eds. J. Zeig and S. Gulligan. Brief Therapy: Myths, Methods, and Metaphors. New York. Brunner Mazel. 327- 341.

Stubblefield, K. (1977). "A Preventive Program for Bereaved Families." Social Work In Health Care. 2(4). 379-389.

Supple-Diaz, L. and D. Mattison. (1992). "Factors Affecting Survival and Satisfaction: Navigating a Career in Oncology Social Work." Journal of Psychosocial Oncology. 10(1). 111-131.

Sze, C. and B. Ivker. (1986). "Stress in Social Workers: The Impact of Setting and Role." Social Casework. 141-150.

Taylor, S. (1983). "Adjustment to Threatening Events: A Theory of Cognitive Adaptation." American Psychologist. November. 1161-1173

Taylor-Brown, S., K.H. Johnson, K. Hunter, and R. Rockowitz. (1982). "Stress Identification for Social Workers in Health Care: A Preventive Approach to Burnout." Social Work in Health Care. 7(2). 91-100.

Tebes, J. K. and D. Kraemer Tebes. (1991). "Quantitative and Qualitative Knowing in Mutual Support Research: Some Lessons from the Recent History of Scientific Psychology." American Journal of Community Psychology. 19(5). 739-756.

Telson, H. and L. Cuoco. (1993). Eds. S. Katz, D. Nardacci, and A. Sabatini. "Innovative Community Living: The Continuing Treatment Program." In Intensive Treatment of the Homeless Mentally Ill. Washington, D.C., American Psychiatric Press, 183-199.

Tesch, R. (1989). Qualitative Research: Analysis Types and Software Tools. Philadelphia, Taylor and Francisco.

Thoits, P. (1983). "Conceptual, Methodological, and Theoretical Problems in Studying Social Support as a Buffer Against Life Stress." Journal of Health and Social Behavior. 23. 145-159.

Thomas, E. (1984). Designing Interventions for the Helping Professions. London, Sage Publications.

Turner, R. (1981). "Social Support as a Contingency in Psychological Well-Being." Journal of Health and Social Behavior. 22. 357-367.

Vachon. M. (1987). Occupational Stress in the Care of the Critically Ill, the Dying and the Bereaved. New York. Hemisphere.

Vattano, A.J. (1978). Self-Management Procedures for Coping with Stress." Social Work. 113-119.

Vinokur, A. and M.L. Seltzer. (1975). "Desirable Versus Undesirable Events: Their Relationship to Stress and Mental Distress." Journal of Personality and Social Psychology. 32. 329-337.

Vinokur-Kaplan, D., S. Jayaratne, and W. Chess. (1994). "Job Satisfaction and Retention of Social Workers in Public Agencies, Non-Profit Agencies, and Private Practice: The Impact of Workplace Conditions and Motivators." Administration in Social Work. 18:3. 93-121.

Volland, P., B. Berkman, S. Stein, and A. Vaghy. Social Work Education for Practice in Health Care: Final Report. New York Academy of Medicine.

Wade, K. and E. Simon. (1993). "Survival Bonding: A Response to Stress and Work with AIDS." Social Work in Health Care. 19(1). 77-89.

Walker, R. (1985). Ed. R. Walker. "An Introduction to Applied Qualitative Research." Applied Qualitative Research. Gower Publishing Co. Limited. England.

Wax, R. (1971). Doing Fieldwork: Warnings and Advice. The University of Chicago Press. Chicago and London.

Wegener, N. (1992). "Supportive Group Services in the Workplace: The Practice and the Potential." Social Work with Groups. 15(2/3). 207-222.

Weiner, M. and T. Caldwell. (1983). "The Process and Impact of an ICU Nurse Support Group." International Journal of Psychiatry in Medicine. 13(1). 47-55.

Weiner, M., T. Caldwell, and J. Tyson. (1983). "Stresses and Coping in ICU Nursing: Why Support Groups Fail." General Hospital Psychiatry. 5. 179-183.

Weisberg, H., Et Al. (1996). An Introduction to Survey Research, Polling, and Data Analysis. Thousand Oaks, California, Sage Publications.

Weisman, A. (1981). "Understanding the Cancer Patient: The Caregiver's Plight." Psychiatry. (44). 161-168.

Weiss, Carol. (1972). Evaluation Research: Methods of Assessing Program Effects. New Jersey, Prentice Hall.

Weitzman, T. and J. Beder. (2000). "The Fieldwork Needs of Graduate Social Work Students in an Oncology Placement: Survey Research." Journal of Psychosocial Oncology. 18(1). 1-15.

Werrbach, G. and E. DePoy (1993). "Working with Persons with Serious Mental Illness: Implications for Social Work Recruitment and Retention." Community Mental Health Journal. 29(4). 305-319.

White, H. and M. Bennett (1981). "Training Psychiatric Residents In Chronic Care." Hospital and Community Psychiatry. 32(5). 339-343.

White, R. (1974). "Strategies of Adaptation: An Attempt at Systematic Description." In Coping and Adaptation. Eds. G. Coelho , D. Hamburg, and J. Adams. New York. Basic Books.

Wilson, D. (1994). "An Outcome Study of a Time-Limited Group Intervention Program for Bereaved Children." (Doctoral Dissertation, Washington State University). Dissertation Abstracts International, #9512796.

Wolfenstein, M. (1966). "How Is Mourning Possible?" Psychoanalytic Study of the Child. 221. 95-123.

Worden, J. (1982). Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner. New York. Springer.

Worden, J. (1991). Grief Counseling and Grief Therapy. (2nd ed.). New York. Springer.

Yalom, I. and S. Vinogradov. (1988). "Bereavement Groups: Themes and Techniques." International Journal of Group Psychotherapy. 38(4). 419-457.

Yin, R. (1989). Case Study Design: Design and Methods. London. Sage Publications.

Zimpfer, D. (1991). "Groups for Grief and Survivorship After Bereavement: A Review." The Journal for Specialists in Group Work. 16(1). 46-55.