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CONFLICTED HELPING:
THE MEDIATOR ROLE OF SOCIAL WORK DISCHARGE PLANNERS IN A RAPIDLY CHANGING HEALTH CARE ENVIRONMENT

by

Joanne Levine

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

1997

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Abstract

CONFLICTED HELPING: THE MEDIATOR ROLE OF HEALTH CARE SOCIAL WORKERS IN A RAPIDLY CHANGING HEALTH CARE ENVIRONMENT

by

Joanne Levine

Advisor: Dr. Mildred Mailick

Studying the mediator role that health care social workers play in discharge planning conflicts provides a view of the rapidly changing health care environment. Social workers have traditionally struggled in this host environment to define their role and status.

Using a random sample of inpatient, health care social workers (N= 600) drawn from the mailing list of national members of the National Association of Social Workers (NASW), intensive follow up efforts yielded a response rate of 67% (n = 402) of which 60% (n = 355) were useable in the data analysis. A highly structured questionnaire obtained both qualitative and quantitative data on relationships between the mediator role, occupational and personal stressors and stress modifiers on job satisfaction and burnout. Six hypothesis explored different aspects of these relationships using techniques of the t - ratio and F- ratio.

The means of the prorated scores revealed that this sample of health care social workers was centrally positioned with regard to overall concern about role overload and role boundary problems. They tended to prefer an integrating over compromising style for resolving discharge planning conflicts. They also reported very high levels of social

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support, were above the midpoint in job satisfaction and reported symptoms of burnout less than once a month. Their attitude toward discharge planning was found to be undecided but leaned towards agreement regarding its importance as function for hospital social workers.

There were three major themes reflected in the qualitative data obtained from this sample; pressure imposed from managed care to discharge patients quickly, negative impacts on staffing due to hospital downsizing and increased competition between nurses and social workers for the role of discharge planner.

Implications from both the quantitative and qualitative data were related to suggested components of a framework for training health care social workers in mediating discharge planning conflicts. These components were: understanding health care economics, overview of mediation interventions, examination of stress reduction techniques and empowerment and political advocacy skills. This study helped to raise larger issues involving the social work profession's commitment to the goal of social justice and whether social change is fundamental to social work education.

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The process of obtaining this degree has been like a long journey with many unexpected stops and detours along the way. Some say that the trip is more important than the destination. While I cannot entirely agree (the destination must be something special if one is to endure journey!), I can say that this journey has left me older, wiser and with a stronger sense of perseverance than ever before. I am glad that many people who I love and care for are still here to share this triumph of fortitude over vicissitudes. I deeply regret that my grandmother, Mollie Gassner, is not still alive to share this with me. If anyone knew the struggle to keep typing when your eyes are tired, your back is hurting and your fingers are stiff, it was she.

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Chapter 1

INTRODUCTION

The rapidly changing health care environment presents many challenges to social workers as they struggle daily in a quest to provide optimal assistance to myriad patients and their families. Medical care has become increasingly complex and expensive, lengths of stay have continued to decrease, managed care aggressively shapes the course of American medicine, hospitals downsize and options for aftercare diminish (Fein, 1995; Globerman, Davies & Walsh, 1996; Berger, Cayner, Jensen, Mizrahi, Scensny & Tractenberg, 1996; Ross, 1993; Cornelius, 1994; Karger & Stoesz, 1998; Cowles & Lefcowitz, 1992) .

Despite these obstacles, social workers help patients and families find their way through the maze of health care and back again to the world (Volland, 1996). Unfortunately, this journey is not always a smooth one. Social workers who provide discharge planning services in hospitals often encounter substantial levels of disagreement among principals in the discharge planning process. (Abramson, 1985; Abramson, Donnelly, King & Mailick, 1993; Donnelly, 1993; Donnelly & Seigal, 1993). Social workers often play a pivotal role in mediating discharge planning conflicts which subjects them to considerable stress (Abramson, Donnelly, King & Mailick, 1993; Cox & Parsons, 1992; Fandetti & Goldmier, 1988; Lurie, 1983; Parsons, 1991, 1992; Donnelly & Seigal, 1993).

Job-related stress has been shown to have catastrophic physical, social and emotional consequences, including a deterioration in the quality of care or of services

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provided; job turnover and absenteeism; low morale; and self reports of personal distress and physical illness (Cooper & Davidson, 1978; Kalimo & Mejman, 1978; Hemmelgarn & Laing, 1991; Maslach & Jackson, 1981; Marriott, Sexton & Stanley, 1994; R. Van Harrison, 1978). Because social workers experience considerable job related stress the posited outcomes of this stress, burnout and job satisfaction, have been discussed extensively in the social work literature (Dillon, 1990; Maslach & Pines, 1981; Pines & Kafry, 1978; Siefert, Jayaratne & Chess, 1991; Taylor-Brown, Johnson, Hunter & Rockowitz, 1982; Ratliff, 1988; Wright, Berg & Creecy, 1987; Wright, King & Berg, 1985).

While attention has been given to disagreements in discharge planning, job satisfaction, burnout and to the mediator role in social work practice; there is a gap in the literature regarding how the mediator role of social workers in the rapidly changing health care environment relates to burnout and job satisfaction. This study explored a variety of relationships involving these and other related variables. The findings were then used to suggest components of a framework for training health care social workers about mediating discharge planning conflicts. The following hypotheses were addressed:

(1) Positive attitudes towards discharge planning will be positively related to job satisfaction and negatively related to burnout.

(2) Responses of men and women will differ with respect to behavioral styles of mediating conflicts which may arise in discharge planning, but the direction of the preference is not clear.

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(3) The preference for using an integrating or compromising style for mediating conflicts in discharge planning is related to job satisfaction.

(4) Occupational and personal stressors will have both direct and indirect effects on the outcomes job satisfaction and burnout, modified by coping resources: inservice and/or additional training in mediating discharge planning conflicts, integrating and compromising styles of handing conflict and social support.

(5) Among the subsample of social workers reporting no inservice and/or additional training over the past year in mediating discharge planning conflicts (controlling for exogenous factors)there will be a negative relationship between role overload and job satisfaction. This relationship will not be observed among the sample reporting they did receive training in mediating discharge planning conflicts over the past year.

(6) Among those social workers reporting a high degree of social support, there will be a negative relationship between role boundary and burnout. This relationship will not be observed among the respondents with low social support.

Importance of the study

The social work role in the American health care system may be seen as a mirror which reflects the most cogent social and economic concerns of the time. The current constraints of regulatory mandates and limited resources create pressure upon patients, families and hospital staff to quickly make crucial decisions about aftercare (Abramson, 1988). It has been suggested this pressure, and the emotional struggles of patients and families to cope with the disruptive impact of illness and hospitalization, result in

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disagreements in discharge planning. Because these disagreements may delay timely discharges and increase negative psychological reactions of the key figures involved, increasing attention has been paid to them by hospital administrators and physicians. This is consistent with the recent recognition of discharge planning as a critical function in health care (Abramson, Donnelly, King & Mailick, 1993; Donnelly & Siegel, 1993).

Social workers assess disagreements in discharge planning from a bio-psychosocial perspective. This greatly enhances their ability to enact the mediator role in order to help resolve those disputes. Social workers see needs and problems as located between the person and his/her environment and/or social network. Thus, disagreements in discharge planning are treated as a psychosocial condition generated by discrepancies between needs and capacities, on one hand, and environmental qualities on the other (Germain & Gitterman, 1980).

This person-in-environment framework facilitates the social work mediator working concurrently with the environment (e.g., regulatory agencies) and the life transition issues presented by patients and families who struggle to cope with disruptive emotional sequella of illness. The collaborative skills of a mediator—intercession, persuasion and negotiation—are used to facilitate the patient/family and their environment reaching out to each other in more realistic, rational and reciprocal ways (Germain & Gitterman, 1980; Germain, 1977).

The mediator role enacted by health care social workers is anticipated to remain an important one as the current political climate lays fertile ground for conditions which give rise to disagreements in discharge planning. New cuts in Medicaid are being proposed in

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addition to the other Federal, state and local reductions on funding imposed in 1996 to various health and social service agencies. These cuts have reduced many of the home and community health services that have made it possible to release patients quickly. With fewer options for aftercare, it is likely that hospitals will face increasing problems when they try and send patients home (Fein, 1995).

This research, and related components for a framework to train health care social workers, has an overall goal of helping them to master the rapidly changing health care environment in which they practice. Having a focus on developing skill goals in health care economics, mediation, stress management techniques, empowerment and political advocacy, are timely for the following reasons.

First, one might anticipate that budget cuts, resulting in more limited options for aftercare, may produce more disagreements in discharge planning. If mediating disagreements in discharge planning continues to emerge as an important social work role, it would thus be important for the social work profession to increase its understanding of the relationship of the mediator role and its sequella to job satisfaction and burnout.

Second, through training, greater expertise in mediation will help the profession further establish its role in discharge planning; a function increasingly the source of competition between disciplines, frequently social work and nursing (Ingelhart, 1990; Kulys & Davis, 1987; Egan & Kadushin, 1995).

Third, interdisciplinary teams are increasingly used in host settings, such as hospitals, for the delivery of human services. It has been observed that team members gain authority by claim to areas of competence (Dane & Simon, 1991). Training which furthers

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social workers' competence in health care economics and mediation may also facilitate their claim to being the discharge planning expert on an interdisciplinary team.

Finally, educating social workers to understand the larger forces in health care which are shaping American medicine may enhance efforts at staff retention. Expertise about cost containment efforts such as managed care should enable social workers to take a leadership role in educating other professional staff, patients and their families. The capacity to use special skills and expertise has been found to be highly related to overall job satisfaction and the prevention of burnout in health care social workers (Marriott, Sexton & Stanley, 1994). There is also less likelihood of turnover when staff are feeling satisfied with their job (Maslach and Jackson, 1981; Siefert, Jayarante & Chess, 1991).

Conceptual Framework

Role based stress

The application of role concepts to clinical practice has long been a key orientation of social workers (Perlman, 1975, 1968; Strean, 1967; 1977; Thomas & Biddle, 1966; Feld & Radin, 1982). This framework is particularly relevant for social work practice in health care because these environments have been reported in the social work literature to engender stress for social workers because they promote role ambiguity and strain (Dane & Simon, 1991).

Stress linked to institutional roles is important to the lives of individuals and to the structure and function of social systems. A worker in any occupation can perform a variety of social roles which have the potential to engender stress (Kahn, Wolfe, Quinn & Snoek, 1964; Osipow & Spokane, 1992; Pearlin, 1983).

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Role overload and role boundary

Role overload and role boundary are two work induced stressors that are particularly relevant to social workers in health care. Discharge planning presents formidable challenges because social workers are required to play simultaneously to a number of audiences while balancing clinical practice demands with organizational priorities (Donnelly, 1992).

Role overload is the extent to which job demands exceed resources (personal and workplace) and the extent to which an individual is able to accomplish expected or required tasks. Role boundary is the individual's experience of conflicting role demands and loyalties in the work place (Osipow & Spokane, 1992). These multiple demands may conflict with one another resulting in a sense of role strain, defined as the "felt difficulty in fulfilling role obligations" (Goode, 1960).

Role strain and role overload have been implicated in contributing to burnout among health and human service providers; a population that is thought to be more susceptible to burnout than other groups (Hoppe, 1990; Pearlin, 1993; Thoits, 1983). It has been suggested that they are particularly prone to burnout because of frustrations which include case overload with no structured "time outs," lack of training specific to the job, inadequate leadership and extensive administration and paperwork tasks (Siefert, Jayarante & Chess, 1991; Ratliff, 1988; Cherniss, 1980).

Responsibility for other people as a factor contributing to burnout and job stress

Human service work makes the responsibility for others' well-being especially strong. If helpers feel that they do not have the proper resources to meet this demand, the

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stress and potential for burnout is strong. This demand for competence is also a reflection of human service workers often feeling that the work is a calling—not just a job. Thus, one's identity and self esteem will be tied to the outcome of the work. Personal identity merges with the work in a way that might seem strange in another type of profession (Cherniss, 1980; Siefert, Jayaratne & Chess, 1981).

Dynamics of job stress and mediation

Cherniss (1980) postulates that stress occurs when there is a perceived imbalance between demands and resources. Stress is defined as a situation in which environmental demands tax or exceed the resources of the person. Whenever an individual encounters a demand, resources are mobilized to meet it. In general, demand is such that if it is not met and neutralized there will be harmful consequences for the person. Demands can be external, such as the threat of job loss, or internal, specific goals and values. The level of stress experienced by the individual depends upon the perceived consequences of failure to meet the demand (McGrath, 1970).

Job stress, therefore, develops when the demands escalate or the resources for meeting these demands dwindle. Client motivation is a crucial and needed resource for meeting the demands of the helping relationship. If a client is uncooperative, resistant or apathetic, even the most skillful helper will not be successful. The lack of client motivation and cooperation prevents the helper from adequately responding to the demands of the job; the quest for competence and efficacy is thwarted. Such a gap between resources and demand will create much stress and strain for the helper. This stress increases the potential for burnout (Cherniss, 1980).

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This model of the dynamics of job stress is useful for understanding how mediation has the potential to function as a stress modifier. Mediation may act as a positive modifier of stress because motivation of the participants is made the center and object of the process. Mediation facilitates and enhances client motivation through techniques which separate people from positions, positions from interests, surface motivation and generate options. This problem-solving process motivates combatants to form a team with the goal of reconciling their apparently conflicting self-interests (Cloke, 1994).

Thus, mediation may be used to generate client motivation—a necessary resource for meeting the demands of the helping relationship. Meeting demands of the helping relationship may enhance the worker's sense of efficacy and psychological success. Stress and strain may then be decreased, minimizing the possibility for burnout and enhancing the potential for job satisfaction.

Conversely, mediation also may result in demands exceeding resources when participant motivation is not generated. The lack of motivation by participants to resolve their dispute can lead to stress and strain for the worker. The worker may be blamed or scapegoated by the disputants. This may occur in the following manner (Cloke, 1994).

Mediation begins with the parties transferring responsibility for resolving a dispute to the mediator and ends as the mediator, piece by piece, returns the dispute to its creators for agreement. In the beginning, parties are at an impasse and feel powerless to effect a solution. By compelling them to adopt pre-set mediation procedures and ground rules, the mediator relieves them of some of their anxiety and burden as well as encourages them to

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trust the mediation process to produce a solution. This may cause the parties to view the mediator as a power broker, regardless of the caveat that it is a voluntary process.

This "procedural transference" helps to relieve the dispute as it dissipates anxiety, reduces concern, frees the parties to discuss their positions more openly, encourages the surfacing of hidden emotional issues and agendas, and increases confidence in the process. However, if this procedural transference is not correct it may result in the adoption of a poor or unfair solution, enforcement problems and blaming the mediator.

The mediator may be used by the parties as a scapegoat due to an incomplete reversal of this opening transference. The mediator may symbolically become an opponent for either or both parties. This need to find someone to blame may reflect an inner blame which has been externalized and projected onto the mediator.

This type of negative feedback from clients may lead to workers feeling unable to achieve efficacy and psychological success in their work. Chronic experiences of this kind may lead to workers experiencing learned helplessness; a passive, defensive coping behavior associated with burnout.

Mediation has the potential ability to be either a positive or negative modifier of stress. It is suggested that effectiveness in mediation depends upon increasing client motivation by doing "with" rather than "for" them. "Doing with" clients can decrease their sense of powerlessness and apathy while facilitating their ability to solve problems and feel competent. Competence increases motivation; a crucial resource for meeting the demands of the helping relationship (Germain & Gitterman, 1980; Cherniss, 1980).

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CHAPTER 2

REVIEW Of THE LITERATURE

Development of the social work role and function in health care

Social work origins in hospitals arose as a response to the medical and social needs created by the ravages of infectious diseases: influenza, tuberculosis and venereal disease. Social workers focused on identifying and alleviating social problems which interfered both with access and follow-up to medical care. Initial depictions of the social worker's role was that of a "helper" to an overburdened physician. The physician delegated to the social worker the task of comprehending and influencing the patient's "many-sided psychic, domestic and industrial environment" (Goldstine, 1953).

This early role evolved into the social caseworker. Social workers gained some autonomous direction of community resources, referred patients to them and facilitated "an understanding of what these various activities meant to the patient in emotional values" (Cannon, 1936).

This focus on integrating a psychological component into the social work role gained further impetus when Freudian theory became assimilated by the profession. Social workers developed expertise on the intra psychic causes of suffering and the role expanded to include psychological treatment functions. Social workers increasingly began to question the control over their function and role by physicians. Ambivalence grew about the circumscribed function of contacting patients and families, solely at the physician's request, for purposes of facilitating access and follow up to medical care. This

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early conflict has been suggested as a background for an historical ambivalence by social work regarding the discharge planning role (Davidson, 1978).

Thus, planning for posthospital care on the referral of a physician, initially welcomed by social workers as a vehicle for their involvement in health care, became less appealing. Within the social work profession increased expertise in psychological diagnosis and treatment functions greatly contributed to discharge planning falling out of favor. Social workers grew to equate this role with physician control over their functions and efforts to deprofessionalize by a circumscribed role of providing concrete rather than therapeutic services (Davidson, 1978; Donnelly, 1992).

Social workers now recognize discharge planning as a professional service with complex functions geared to meet the needs of both the patient and the hospital. Hospital based practice as a discharge planner is comprised of several interrelated and challenging roles: patient and family advocate, educator, counselor, mediator, information and referral specialist and humanizing force in an often impersonal and high-tech hospital environment (Abramson & Black, 1985; Brown & Furstenberg, 1993; Caputi, 1978; Fandetti & Goldmier, 1988; Foster & Brown, 1978; Lurie, 1983; Parsons & Cox, 1982, 1992).

To further understand one facet of social work practice in hospitals—mediating disagreements in discharge planning—is to join with a trend reflected in the social work literature. This is to clarify and elucidate roles enacted by social workers in health care through research conducted by and for social workers.

Donnelly (1992) has stressed the importance of defining the social work role in hospitals because role definition is a vehicle for orienting expectations. Donnelly states:

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> Hospital social workers play to a number of audiences simultaneously: patients and their families, hospital administrators and nonprofessional staff and other professionals in the treatment team. The consequences of neglecting this role defining task can be dramatic for the individual worker both in terms of burnout, declining morale and loss of influence and access to resources in a climate of fiscal constraint. (p 107)

Incidence and sources of disagreements in discharge planning

Social work research on discharge planning not only alludes to the conflictual nature of the process but attempts to identify the incidence and sources of these conflicts.

An initial study on disagreements in discharge planning was conducted by Abramson (1985) who conceptualized discharge planning as a negotiation among many different interests, represented by a variety of individuals. Medical social workers engaged in discharge planning were therefore asked to identify disagreements in discharge planning between: the patient and family; within the family; among the patient, family and social worker; among the patient, family and doctor; and among the doctor, nurse and social worker.

Findings from this study indicated that conflict was indeed a common occurrence between the key figures involved. There was disagreement between at least two of the principals during the discharge planning process in 51 percent of the cases. At the point of discharge, there was still disagreement in one quarter of the cases. During the discharge planning process, there was disagreement between 28.5 percent of the patients and families and 23.6 percent between the patient and social worker. Physician/family

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disagreement and social worker/family disagreement occurred in 16.2 percent of the cases. By the point of discharge, disagreements persisted between all the key figures although to a lesser degree than during the discharge planning process.

These results clearly indicated a great need for the social worker to function as a mediator between the patient and other key participants in the discharge planning process. As well, it was concluded that social workers have an important role in educating other health professionals about the potential negative consequences of disagreements for the patient and family. Perhaps the most destructive consequence of disagreements among key participants noted is the potential to increase the patient feeling a loss of control. Elderly patients who feel out of control are reported to often have serious difficulty adjusting to their post-hospital environments. Families may also suffer by experiencing depression and guilt in addition to their struggles around coping with the emotional impact of the illness.

Abramson, Donnelly, King and Mailick (1993) reviewed the current literature on discharge planning and emphasized the normative nature of conflict in this process. This aspect of discharge planning may impede the formation and outcome of a discharge plan and cause detrimental emotional effects for patients and families.

This same literature review illuminates how some studies also indirectly provide insights into the roots of these disagreements. For example, studies that link reductions in the length of stay to screening and early intervention by social workers with high-risk patients imply that conflict may arise from tensions which arise between the clinical and administrative missions of discharge planning.

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Studies which explore concerns by the principals involved in discharge planning about the adequacy of the plan imply that the patients' discharge destination, the planning process itself and self-determination issues may also give rise to conflict (Morrow-Howell, Proctor & Mui, 1991). Ethical dilemmas for all principals involved in discharge planning were also identified as a significant aspect of discharge planning complications. There was a recurring theme of conflicts between the regulatory and organizational requirements of agencies (Proctor & Morrow-Howell, 1990).

Donnelly & King (1990) defined disagreements in discharge planning as conflicts that required social work intervention. Their study involved social workers in urban teaching hospitals and the disagreements occurred in 35% of the cases. Disagreements most frequently occurred between family members and hospital staff (23%) followed by: disagreements between family members and patients (17.6%); between family members only (15.8%); the patient, family and hospital staff simultaneously (15.5%) and among hospital staff only (7.9%). Overall, 71% of the discharge planning cases exhibiting disagreement involved family participants.

Implications for social work practice was discussed. From a family systems perspective, the social work role in discharge planning is seen as assisting patients and families with the central task of readjusting their roles and expectations in the face of illness. In contrast, the medical model which views the patient as central, may lend itself to a more adversarial view of the family when conflict occurs between the patient and family during this readjustment phase. Given that disagreements may occur during the planning

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process, it is suggested that a crucial skill for social work discharge planners to further develop is their ability to assess and mediate disputes.

Donnelly & Siegel (1993) discuss a qualitative follow-up study on disagreements in discharge planning in which 54 social workers selected a case which had both family involvement and a significant degree of disagreement in discharge planning. In this sample, the majority of patients had a chronic illness and multiple diagnoses.

The social workers reported the following about their difficult cases. During the admission, 75 percent of these patients were felt to undergo significant emotional or physical changes and 50 percent of these patients and families had unrealistic expectations about the outcome of the admission. The power for decision-making in discharge planning lay with the family in 50 percent of the cases.

The focus of the disagreement for 59 percent of the cases lay in the destination or level of care from the current admission. Other foci of disagreements were the families' lack of cooperation in discharge planning, type or availability of services for aftercare, conflicts about patient self-determination, and disagreements about the patient's readiness for discharge. In over 80 percent of the cases, the social workers were involved in negotiation between the family system and the hospital. Their interventions were seen as a key element in the discharge planning process.

Of further interest was that patient age emerged as a significant factor contributing to disagreements in discharge planning. Almost half of the cases involved patients between 20 and 64 years of age and another third were over 75 years old. For the first age group, Donnelly and Siegel propose that illness creates conflicts with life cycle tasks and

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expectations that others have for this age group. For the older group, it is suggested that each hospital admission leads to an exacerbation of their problems and a mounting burden on the patient's family to care for them. Eventually, the patient's problems may become so burdensome that the family will not want to care for them any more. This inability or lack of interest in caring for the elder may contribute to the onset of disagreements in discharge planning.

The preceding studies identify the frequent occurrence of disagreements in discharge planning and the variety of significant factors contributing to these disagreements. Conflicts may arise between or among the patient, family and hospital staff. The emotional reactions to illness and disability—the social, economic and familial repercussions--all converge to create a highly-charged arena for discharge planning. Families may be seen as being forced to deal with the needs imposed on them, especially by chronic illness, and seeking to have the hospital accommodate them in this struggle. It is suggested that the hospital may then become more crucial as a resource as the family system weakens through age, death or the cumulative system of multiple readmissions. The hospital discharge planning process, and the disagreements which ensue, are at the center of the patient's and family's efforts to reorganize and rebalance the family system impacted upon by illness. By reframing disagreements in discharge planning in this way, conflicts which arise in the process may be seen as a source of positive change rather than only being a barrier to timely discharges (Abramson, Donnelly, King & Mailick, 1993; Donnelly & Siegel, 1993; Donnelly, 1992).

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Current challenges to the social work discharge planning role

The social work literature elucidates the social work discharge planning role while also acknowledging that claiming primary control over this function may be an increasing challenge to the profession. Several factors are felt to contribute: hospitals as host settings (Dane & Simon, 1991; Mizrahi & Abramson, 1985); blurred role definition of the medical social worker (Lister, 1980; Egan & Kadushin, 1995; Davidson, 1990; Cowles & Lefcowitz, 1992); increasing competition between nursing and social work for control over discharge planning functions (Ingelhart, 1990; Kulys & Davis, 1987; Egan & Kadushin, 1995) and the growing presence of managed care and prospective payment systems (Cornelius, 1994; Mizrahi, 1993).

Hospitals, host institutions to social workers, give rise to questions of professional turf and autonomy because many professionals are concerned with similar activities and interventions related to the client's welfare (Dane & Simon, 1991). In health care settings, social workers are not always perceived as the only professionals qualified to perform social service tasks and discharge planning (Cowles & Lefcowitz, 1992; Kulys & Davis, 1987; Egan & Kadushin, 1995).

Hospital social workers may perceive themselves as the most qualified provider to provide the assessment, counseling and coordination inherent in the discharge planning process. However, other disciplines may not share this point of view. Several studies report that physicians and nurses expect social workers to arrange for the concrete service portion of the discharge planning process but do not expect social workers to perform psychosocial tasks. Nurses are reported to view themselves as qualified to assess and

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intervene in the social and emotional problems of patients and families or to view these tasks as areas for collaboration (Cowles & Lefcowitz, 1992; Lister, 1980; Kulys & Davis, 1987; Egan & Kadushin, 1995; Ingelhart, 1990).

The social work literature contains efforts to understand how this lack of role definition has occurred. A common theme to emerge is that the role of the medical social worker in the acute care hospital has never been clearly defined. Since at least the mid-1950s, the literature has reported medical social workers feeling that their role in direct service is misunderstood by other health care professionals, especially physicians. Patterns observed in these studies suggest that role ambiguity and strain may arise from the social work profession taking the position that its distinguishing focus is the person-in-environment. This focus means that social workers expect their direct service role to be fairly equally directed to both emotional and social-environmental problems of both the primary client and his/her family. However, other professional groups may not be attuned to this position of the social work profession. Rather, there may be a narrower focus of the social-environmental problems of people and on connecting them with concrete services and community resources (Lister, 1980; Cowles & Lefcowitz, 1992; Dane & Simon, 1991).

A lack of clear role expectations can enable a profession to assume new roles and functions thereby constituting an encroachment on the domain of the profession claiming these functions as its own--even when there is no consensus these tasks belong to it (Donnelly, 1992; Egan & Kadushin, 1995; Davidson, 1990). Such is the case with nursing,

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which has moved into discharge planning; an area which social work has considered to be its primary responsibility and domain (Ross, 1993; Ingelhart, 1990; Kulys & Davis, 1987).

There is a trend in the social work literature to emphasize the different strengths which social work and nursing bring to discharge planning. However, there are also caveats that overlapping and duplication of functions by social workers and nurses may have serious consequences within the cost conscious hospital organization impacted upon by prospective payment systems and managed care. It has been suggested that if professions are perceived as duplicating functions, nonessential personnel may be eliminated as a cost saving mechanism (Egan & Kadushin, 1995; Ross, 1993; Kulys & Davis, 1987; Ingelhart, 1990).

Under managed care, utilization is firmly in the hands of the case manager who is in control of funding for post-hospital care. Every clients case is also structured according to the protocols of the managed care firm. In managing the case, the case manager determines whether the service is medically necessary and if that service is covered by a commercial contract. Thus, managed care takes control of the planning away from the health care team and the patient because the main goal is cost containment. This intensification of bureaucratic control by managed care over discharge planning is also another source of role strain for social workers whose central mission is to maximize the resources and choices of patients (Cornelius, 1994; Mizrahi, 1993; Dane & Simon, 1991).

In response to these challenges, recommendations in the social work literature include: cautioning social workers to not weaken their power base by carelessly abdicating professional territory to other individuals or professional groups; maintaining the right of

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final review and approval for any shared task and making a greater effort to orient other groups to the person-in-environment perspective of social work. As well, in the current climate of managed care, social work discharge planners are encouraged to use every contact with case managers to express their priority—to meet the needs of the patient (Ross, 1993; Cornelius, 1994; Cowles & Lefcowitz, 1992).

Conflicts as the context for the mediator role in social work practice

The role of social work in society has often been conceptualized as that of a mediator. Social workers mediate the individual-social engagement, between group members and the systems that impinge upon them and at the boundary of systems. These interacting systems are recognized to have power and value differences; therefore, interactions are likely to be confrontational and conflictual. The recognition of this inherent conflict provides the context for the mediator role (Fandetti & Goldmier, 1988; Lurie, 1983; Parsons, 1991).

Mediation is defined as the use of a bias-free third party to help disputants find and agree to an acceptable resolution of their conflict by way of a private and confidential process. The purpose of mediation is to assist the parties by offering a process for reaching settlement. The mediator does not act as a judge and has no power to impose an outcome on the parties. Rather, the mediator facilitates the process of negotiation between the parties, helping them to better understand the options and their consequences. The outcome of mediation is determined by the parties; they each exercise the authority to reject or accept the offers presented them (Dubler & Marcus, 1994; Parsons, 1992).

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In the role of mediator, the social worker generally carries out the function of helping the client and the social system reach out to each other in more realistic, rational and reciprocal ways through the collaborative skills of intercession, persuasion and negotiation. If the collaborative skills of the mediator role do not accomplish the desired end, the social worker may then carry out the advocate role and call upon the adversarial skills of pressure, coercion or appeals to third party intervention (Germain & Gitterman, 1980).

The skills of a mediator are useful in a variety of social work functions including discharge planning. These skills are firmly based in the premises upon which the social work profession originated; client advocacy and community organizing. Skills derived from these prior, established roles of advocate and organizer now enable social workers to negotiate the political processes inherent in the discharge planning process: mediation, arbitration and negotiation (Lurie, 1983).

The current health care climate presents formidable obstacles to making optimal decisions about patients aftercare. There is pressure for quick discharges which may cut short the decision-making process leaving patients and families to struggle with guilt, grief and post-decision regret. Also present are limited options for post hospital care. Patients and families may also sometimes not be fully involved in the planning process. All these factors have been identified as contributing to patients and families dissatisfaction with discharge plans, their psychological distress during and after the planning process and the onset of disagreements in discharge planning (Abramson, 1988; Coulton, Dunkle, Goode & Mackintoch, 1982; Coulton, Dunkle, Chow, Haug & Vielhaber, 1988, 1989; Garber,

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Brenner & Litwin, 1986; Morrow-Howell, Proctor & Mui, 1991, Janis & Mann, 1982; Proctor, 1992).

Practice interventions and implications

The mediator role differs from the therapist or advocate roles also enacted by social workers in health care settings. In the mediator role, the social worker acts to promote reconciliation, settlement, compromise or understanding among two or more conflicting parties (Dworkin, Jacob & Scott, 1990; Gold, 1985).

Mediation may be further understood as a behavioral style of handling conflict through the use of interventions such as integration and compromise. Integration involves the exchange of information and the examination of differences in order to reach a solution acceptable to both parties. Integration is associated with problem solving that may lead to creative solutions. Compromise involves sharing whereby both parties give up something to make a mutually acceptable decision. It may mean splitting the difference, exchanging concessions or seeking a middle ground position (Rahim, 1983).

Mediation is problem based and problem solving with the desired outcome a mutually acceptable behavioral agreement. The focus is on problem solving, not behavior or personality issues. Personal changes are a secondary outcome of agreement seeking. A suggested framework for mediation interventions by social workers is as follows:

(1) Separate the people from the problem;

(2) Focus on interests instead of positions;

(3) Create options that satisfy interests of the participants;

(4) Select criteria for choosing alternatives (Parsons, 1991, 1992, 1993).

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The social worker who enacts the mediator role must skillfully establish a balance between task and process. When the relationship between the disputants is ongoing, the process of mediation is equal to and sometimes more important than the outcome. It is strongly emphasized that the relationship and future relationship of those involved weigh out carefully in the mediation process (Bisno, 1988; Fargo, 1986, Kolb & Rubin, 1989; Kressel & Pruitt, 1989, Parsons, 1993, White, 1985).

The positive effects of mediation in a variety of settings

Mediation has been used successfully both internationally and in the United States. China, for example, has only a few thousand lawyers for over a billion people. Nearly 7 million mediators are elected in neighborhoods, factories, schools and farms to settle conflicts before they become lawsuits. There are over 60,000 professional mediators attached to the courts who use mediation before trial. Judges, police officers and lawyers have all been trained in mediation techniques and it is common for trials to recess so the parties can return to mediation. Nationally, China has a 90.2% settlement rate in mediation (Cloke, 1994).

In the United States, mediation has been most recently developed to divert certain types of disputes from the backlogged formal court process. At least 35 states and Washington DC have instituted mediation to deal with domestic disputes. It is believed that if couples can resolve their disputes in a minimally antagonistic, non-adversarial environment, then the volatile nature will be diffused and the children will benefit (Severson & Bankston, 1995).

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Empirical evidence suggests that mediation is a sound and effective strategy in divorce and child custody disputes (Bisno, 1988; Fargo, 1986; Kolb & Rubin, 1989; Kressell & Pruitt, 1989; White, 1985). In divorce cases, of which about one million occur each year, 10 percent are referred to mediation and 93 percent of these cases never return to court. When the need for changes in these mediated agreements arose within the year following the divorce, the majority of ex-spouses (98 percent) were able to alter these agreements on their own rather than relying on third parties (i.e. attorneys). This suggests that the process of mediation may enable couples to develop effective communication and negotiation skills (Severson & Bankston, 1995).

Mediation programs are also being developed for other populations. A senior to senior mediation service developed by the University of Denver Institute of Gerontology focused on situations which lend themselves to conflict for the elderly; age discrimination disputes, public benefit disputes, estate and long-term planning disputes. Although many cases were complex, a jointly agreed resolution was achieved in 27 out of the 39 cases mediated in the first 9 months of the program. Both the complainants and the mediators reported great feelings of satisfaction and empowerment through the work and its outcomes (Cox & Parsons, 1992).

In health care, The Bioethics Consulting Service at the Montefiore Medical Center started a project to develop a mediation program for hospital staff. They developed a model of mediation which recognizes that bioethical disputes are composed of a number of components, including uncertainty about medical facts, complexity of the medical staff hierarchy, potential disempowerment of patients and families in the unfamiliar, high

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technology setting of the hospital and anxiety about sickness and death. Mediation was felt to provide a useful set of techniques for examining bioethical disputes because it helped to establish the medical facts and offered a setting in which all of the medical evidence and the perspectives of caregivers could be examined and questioned. As well, mediation provided a forum for continued decision making in any case and facilitated staff, patients and families sharpening their understanding of the medical, ethical and legal issues involved (Dubler & Marcus, 1994).

From the preceding, positive aspects of mediation for social work practice may be extrapolated.

Mediation, from an ecological perspective, is seen as having a focus on helping clients make use of available resources and on influencing organizations to provide responsive services. As well, the social worker's professional function as mediator becomes one of helping clients use the adaptive and coping resources of their social and physical environments that are available and accessible to them. If the client is unable to use these resources, the mediator role facilitates the social worker helping the client reduce his/her fears, relax the resistance and/or acquire the necessary knowledge to make decisions and use relevant services (Germain & Gitterman, 1980).

Mediation has also been identified in the social work literature as an empowering intervention for patients and families who struggle with the emotional impact of illness and the discharge planning process. The empowering qualities of mediation are an emphasis on each participant taking responsibility for their decision making and the outcomes;

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improvement in family support and greater sophistication by the patient and family in their problem solving abilities (Parsons, 1992).

Finally, other positive aspects of mediation include: allowing both sides to win, an opportunity to see the problem as a whole and to receive constructive feedback without judgment. Mediation also gives the social work practitioner an opportunity to model useful behaviors and techniques for avoiding future conflicts (Cloke, 1994).

Cautions and constraints of the mediator role in social work practice

Mediation traditionally emphasizes the bias-free stance of the mediator. However, it should be noted that complete neutrality conflicts with the value base of practice. This conflict compounds those already faced by social workers in health care. Within the larger context of advances in medical technology and the subsequent dilemmas, social workers have reported a strain in their ability to implement professional social work ethics. Major goals of social work are to enhance social functioning and foster maximum client participation. These goals may be difficult to implement in an environment where the use of technology raises complicated issues about allocating scarce resources, changing definitions of personhood and decisions about when life begins and ends (Abramson & Black, 1985; Caputi, 1982). Exploring ways to maintain neutrality in a manner compatible with social work practice therefore remains a conceptually challenging area for future research.

It is also important to assess whether or not the conflict is appropriate for mediation, thereby ensuring that this is the best intervention to use. Mediation is not appropriate when a determination has been made that a decision will be imposed upon one

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or all of the parties, either as result of legal, ethical, moral or clinical considerations and there is no room for negotiation. There must be more than one way to settle the disagreement. Even to suggest that there is room for negotiation when a decision has already been made is fraudulent (Parsons, 1992; Dubler & Marcus, 1994).

It is also crucial to assess that all participants are competent to negotiate. It is very important for the social worker to make all efforts, including interdisciplinary consultation, to ensure that patients are mentally competent prior to involving them in mediation (Parsons, 1992). Failure to do so may lead to serious negative consequences for those involved including financial exploitation, misunderstanding the choices available and their consequences, and violation of legal and patients' rights.

This raises another concern: accurate identification of various characteristics of conflict which may make it impossible to mediate in a particular circumstance. The social worker must assess that all the parties to a mediation must want to reach agreement. When one party genuinely seeks blood, mediation is impossible; the urge for revenge may be remedied in therapy, but not in mediation. As well, if the disagreement involves an individual with strongly held religious beliefs or value preferences, involving them in mediation may cause the other party to capitulate in an unfair manner. This raises the further concern that the resolution may be basically unjust because of long-standing dysfunctional patterns or outside pressure. In those cases where there is implacable opposition to patient or family choice, the social worker must assess the need to involve a properly empowered administrative person or body (Dubler & Marcus, 1994; Cloke, 1994; Parson, 1992).

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Studies on women in divorce and child custody disputes have raised concerns about mediation placing them at a disadvantage, and therefore vulnerable to exploitation (Regehr, 1991). These concerns, which follow, may be extrapolated to other vulnerable populations whom health care social workers assist with discharge planning.

The first concern is that the absence of public scrutiny and legal protection over mediation may result in traditional patterns of inequity to flourish outside of public view. Individuals who are less empowered need formal legal systems and representation to protect their rights and pursue new legal safeguards; an adversarial proceeding is often the best way to protect the rights of parties.

The second concern, is that much of family mediation theory is based upon a systems approach to family therapy. One hallmark of systems theory is that it employs a nonblaming notion of systemic interactions that removes individual responsibility. The concept of mutual responsibility for problems in systems theory may inadvertently hold victims responsible for their victimization. This issue of circular causality is particularly pronounced when discussing mediation of couples who have a history of physical or emotional abuse. Many proponents feel that situations involving abuse should not be mediated as it may increase the risk of harm to the victim as well as reinforce antiquated notions about state nonintervention in husband-wife conflicts.

A final concern is that mediators may not identify issues of power in mediation because a claimed advantage of mediation is that parties are in control of their own decisions. In fact, parties may not come to mediation with equal bargaining power. This

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may result in causing any agreement raised in mediation to simply reflect the power imbalance which exists between the parties.

From the preceding it is clear that, as is the case with any clinical intervention, the social worker must assess whether using mediation is appropriate. The social work and related literatures have identified several factors to guide this decision: determining whether there is more than one way to settle the disagreement, assessing that all parties are competent to negotiate, and that all involved are committed to reaching an agreement (Parsons, 1992; Dubler & Marcus, 1994; Cloke, 1994; Regehr, 1991). As well, the social worker who assumes the mediator role must be very well aware of their own values and biases. Social workers must be able to separate themselves as individuals in order to become bias-free facilitators of the process (Severson & Bankston, 1995).

The stress process, role based stress and occupational stressors

There are three recognized elements in the stress process: stressors, stress outcomes and moderators. A stressor is an objective circumstance that has the potential to cause psychological reactions in persons who find themselves in this circumstance. Stress outcome refers to the subjectively experienced reactions to a stressor. A moderator describes an interaction effect; it means that the relationship between a stressor and an outcome depends on the presence, absence or level of the moderator (Hoppe, 1990; Pearlin, 1989).

Two of the most common mental health outcomes associated with work stressors are burnout and job dissatisfaction. Burnout specifically describes job-related stress and involves feelings of emotional exhaustion, cynicism and futility (Maslach & Jackson, 1982;

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Cherniss, 1980). Job dissatisfaction is also a stress outcome but differs from related notions of job commitment, burnout or intention to quit the job. It is a pressing problem for organizations and professions with high turnover or attrition (Hoppe, 1990; Koeske, Kirk, Koeske & Rauktis; 1994).

The most commonly examined moderators of stressors on stress outcomes are personal coping resources and social support. This is the extent to which the individual feels support and help from those around him/her (Hoppe, 1990; Osipow & Spokane, 1992).

The following review of research from the social work and organizational psychology literatures examines work stressors, concentrating on role strain, inter-role conflict and role loss. The results of these studies are equivocal, showing variable findings related to the impact of work stressors. This can be explained by differences in (1) study samples, including the demographics and the organizational or community contexts in which they were drawn; (2) stress outcome measures; (3) the inclusion of moderators of stressors (personal coping resources and social supports) on stress outcomes (Hoppe, 1990). The following studies have been grouped in relation to the exogenous factors: gender, age, marital status, ethnicity/race and educational level and special skills.

Women workers have been shown to experience gender-related work stress. One study found that professional woman, as contrasted with professional men, experienced four times as much job tedium; felt they has less freedom, autonomy, influence, variety and challenge in their job and believed that their work environment was less positive (Pines, Aronson & Kafry, 1981). Other researchers reported that women therapists experienced

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greater levels of stress and emotional exhaustion than did their male counterparts (Maslach, 1981; Ratliff, 1988).

Conversely, Hazuda et al. (1986) found that employment outside the home may protect women from coronary heart disease as was shown by data gathered from Mexican American and non-Hispanic white employed women and housewives. As well, working mothers in Canada with higher levels of social support, reported lower levels of role strain than those working mothers who reported less social support thereby experiencing psychological benefits of employment outside the home (Hemmelgarn & Laing, 1991).

From the preceding review, it is seen that empirical studies comparing levels of distress among working women, housewives and or/men have yielded inconsistent results. As a body of research, they do not fully support theories which postulate that multiple roles decrease the risk of distress by providing individuals with multiple reasons and purposes for their existence (Hoppe, 1990).

It has been suggested that an explanation for these contradictory findings on the effect of employment on women's well-being may be found in a synthesis of role conflict and power perspectives. Effects of employment for women are not consistently positive because employment outside the home involves trading one source of low control for another. Thus, in situations of low demands (no children or help from the spouse with child care) employed women have symptoms of stress equal to those of men and significantly lower than housewives (Rosenfield, 1989).

The age of a worker has been explored in relation to occupational stress. Maslach and Jackson's (1981) study of male and female health and service professionals implied

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that burnout is most likely to occur during the first few years of one's career, causing some individuals to leave their profession. Pearlin (1966) reported that high levels of emotional tension caused by the job tended to be more common among younger workers than older workers. However, if the younger workers were not in a supervisory position, the degree of association between age and tension was substantially reduced. Finally, Pines and Kafry (1978) found that occupational tedium in the social services was lower among older homemakers than younger caseworkers. They caution, however, that other factors such as differences between these groups in their lengths of employment, educational and job levels may influence the findings.

The preceding review highlights both the complexity of disentangling the relationship of age to factors such as job burnout, emotional tension and tedium and the importance of including age as an exogenous factor.

Not being married has been found to be significantly related to emotional exhaustion: a syndrome of feeling no longer able to give of the self at a psychological level and the development of negative, cynical attitudes and feelings about one's clients (Maslach & Jackson, 1981; Siefert, Jayaratne & Chess, 1991). Of interest, however, is their finding that over a ten-year span, lack of physical comfort replaced being unmarried as a significant contributor to burnout (Siefert, Jayaratne & Chess, 1991). Regarding these findings about marital status and burnout it may be that the important factor is not marital status but a proxy variable, quality of relationship, which is a not discussed in these in studies of burnout.

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A study of black, female managers in human service organizations reported that single managers were more likely to than others to have high levels of job satisfaction. It was suggested that single women may be able to focus their energies on the job more than married women and perform in ways that increase satisfaction (Wright, King & Berg, 1985).

When discussing marital status, it is relevant to note that the above findings may relate to the larger evidence about the relationship among work stressors, social support and stress. Although inconsistent, strong perceptions still exist of the buffering role of social supports in the prevention of job burnout, tedium and role strain (Pines & Kafry, 1978; Pearlin, 1989; Hemmelgarn & Laing, 1991; Hoppe, 1990). However, further research is needed to learn more about the interactional aspects of support and about the effects of social contexts on its forms, functions and efficacy (Pearlin, 1989).

Many studies conducted on both burnout and job satisfaction among health and service workers utilize samples composed primarily of Caucasians (Quinn & Staines, 1979; Pines & Kafry, 1978; Maslach & Jackson, 1981; Siefert, Jayaratne & Chess; Elo, 1994). Other reports fail to make mention of the ethnicity and/or race of the sample under study (Zautra, Reynolds & Eblen, 1987; Cooper & Marshall, 1978; Marriott, Sexton & Stanley, 1994).

Having samples which consist almost exclusively of one ethnic/racial group obviously precludes comparisons of how race and ethnicity may correlate with occupational stress. Due to relatively small numbers of ethnic minorities in their overall

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sample, Maslach and Jackson (1981) were not able to find any significant differences related to the ethnicity in their study of burnout among health and service professionals.

One study which did examine differences in job satisfaction between Caucasian and African-American workers was the 1977 Quality of Employment Survey conducted by the Institute for Social Research, University of Michigan (Quinn & Staines, 1979). Differences between the two groups were studied in the years 1969, 1973 and 1977. The trend was a decline for both groups in job satisfaction with the amount of decline in satisfaction being virtually identical for both groups of workers. However, it was observed that African-American workers continued to remain less satisfied than their Caucasian counterparts. This study did not seek to examine possible reasons for this difference between racial groups.

Some explanation, however, may be suggested in the work of Pearlin (1989). He highlights the importance of understanding the impact of various social systems of stratification that cut across societies, such as those based on race and ethnicity. To the extent that these systems embody the unequal distribution of resources, opportunities and self regard the continual difference between Blacks and Whites in job satisfaction is perhaps a reflection of these larger systems of social stratification.

Work stressors (role strain, inter-role conflict and role loss) have been extensively studied in Mexican-American women. It has been hypothesized that because prestige, power and self - esteem for women in the Mexican culture derive in large part from the role of housewife and mother, Mexican-American women who retain these values should

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be more vulnerable than others to the negative effects of employment (Ross, Mirowsky & Ulbrich, 1983). Findings, however, have been contradictory.

Employed urban Mexican-American married woman are reported to reframe any marital stress ensuing from their work outside the home in positive terms due to the personal gratification gained from their non traditional female roles (Williams, 1988). A three-generational study of women in Mexican-American families found that employment had generally positive psychological effects. This study further reported that separated and divorced women benefitted from paid employment more than married women (Krause & Markides, 1985).

Other studies, however, have failed to demonstrate consistent positive psychological effects of employment for Mexican American women. No significant differences were found in depression levels between employed men and employed women who were married (Roberts & Roberts, 1982). Another study reported that employed women and homemakers showed no differences in depression levels (Saenz, Goudy & Lorenz, 1989). The 1979 National Chicano Survey reported that employed women had lower marital satisfaction than housewives. This may suggest that Mexican-American women may not receive sufficient help from husbands in coping with the demands of multiple roles (Saenz, Goudy & Lorenz, 1989).

Finally, Wright and colleagues (Wright, King & Berg, 1985; Wright, Berg & Creecy, 1987) studied perceived job stressors, organizational characteristics and job satisfaction among Black female managers. Married female managers had lower levels of job satisfaction than single managers. It was suggested that the lack of job opportunities

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for Black males and possible status differences between these husbands and their managerial wives might have created marital strains which affect job satisfaction.

A worker's level of education and special skills have been examined as a background factor in the studies below; the findings suggest that education is relevant for inclusion in occupational stress research.

Maslach and Jackson (1981) report that differences by level of education were found for each of the subscales of their Burnout Inventory. Most significant was the finding that more education was associated with emotional exhaustion and greater feelings of personal accomplishment.

In a survey of psychiatric social workers (Marriott, Sexton & Stanley, 1994), the capacity to use special skills and expertise was found to be consistently and highly related to overall job satisfaction; demoralization accompanied discouragement in the use of skills.

Conversely, in a study of employed mothers in Canada, education was not found to be significant in predicting role strain. The results suggested that maternal identity, or the confidence and comfort a woman experiences in the maternal role, was the strongest predictor of role strain. This study also supported the proposition that social supports act as buffers in decreasing the harmful effects of stress. Mothers with more social support experienced less role strain (Hemmelgarn, 1991).

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Chapter 3

METHODOLOGY

Sampling procedure

The sample was drawn from the mailing list of members (153,788) of the National Association of Social Workers (NASW) based on their count as of October 1,1995 . The sample was limited to social workers in the continental United States who indicated their work setting was inpatient medical/ health care. The 600 inpatient health care social workers comprising the sample for this study, were randomly selected from a sampling universe of 16, 817 inpatient health care social workers.

The sample was limited to inpatient medical/health care social workers because the bulk of discharge planning occurs on inpatient services and prior social work research has primarily focused on these settings (Abramson, 1985; Abramson, 1988; Abramson, Donnelly, King & Mailick, 1993; Coulton, Dunkle, Chow, Haug, & Vielhaber, 1988, 1989; Donnelly, 1983; Morrow-Howell, Proctor & Mui, 1991; Ingelhart, 1990; Dane & Simon, 1991; Davidson, 1978, 1990; Kadushin & Kulys, 1993,1995; Siefert, Jayaratne & Chess, 1991; Marriot, Sexton & Staley, 1994).

Participation in this study was voluntary and confidentiality of the data was assured by coding the questionnaires, removing the respondent's name and keeping the mailing list in a separate locked file accessible only by the Principal Investigator.

Data collection

Data collection occurred from November 15, 1995 through early March, 1996. Each social worker was sent up to three mailings if they did not respond . The first mailing

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consisted of a cover letter, questionnaire and stamped, self addressed envelope. These were sent to 500 inpatient medical/health care social workers randomly selected from the mailing list of NASW. If they did not respond to the first mailing, follow up postcards were sent on December 15th and 30th, 1995.

Because some (n = 47) of those from the initial sample returned responses indicating they were retired (n = 20) or currently employed in another work setting (n = 27), NASW was recontacted. Another 100 inpatient medical/ healthcare social workers were sampled from the sampling universe of 16, 817; this resulted in a total sample of 600 (see Table 1). On January 6, 1996 they were sent the cover letter, questionnaire and stamped, self addressed envelope. On February 1st and 20th, those who had not responded were sent follow up postcards. This extended the total time for data collection through early March, 1996.

These efforts yielded a response rate of 67% (n = 402) of which 60% (n= 355) were useable for the data analysis (see Table 1). Typically, mail surveys produce low response rates. This excellent response rate may be primarily attributed to the following factors; the relatively brief, completely structured questionnaire, intensive follow up and access to a literate and identifiable population who were highly motivated about the topic being studied (Bourque & Fielder, 1995).

It should be noted that in addition to filling out the questionnaire, 75 subjects (19%) also wrote detailed comments reflecting their experiences, hopes, concerns and recommendations for social work practice in the current rapidly changing health care environment. As well, 51% of the sample reported experiencing Disturbing Life Events

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over the past year with many providing written information on up to three of the most upsetting ones. The qualitative data grounded this study in the day to day lives and practice experiences of health care social workers and was therefore a major influence in the understanding and interpretation of the quantitative data.

Table 1: Overview of Sample (N = 600)

Category	N	%
Inpatient medical/health care social workers	355	60
Questionnaires not returned	191	31
Social workers currently not in health care	27	5
Retired social workers	20	3
Social workers not interested in participating in study	3	.5
Questionnaires returned with no forwarding address	4	.5

The questionnaire

The questionnaire comprised nine sections: Work Setting; Discharge Planning Attitudes; Job Attitudes; Job Satisfaction; Conflict Management; Job Related Feelings; Social Supports; Background Information About You and Additional Comments. There were a total of 156 variables.

Work Setting solicited information about the social worker's place of employment such as the type of hospital, primary work area, level of position and how many hours of inservice and/or additional training in mediating conflicts were received over the last year. There are also sections on the tasks performed in discharge planning and on factors contributing to disagreements in discharge planning.

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The Job Attitudes section measured the occupational stressors of role overload and role boundary through the Role Overload and Role Boundary subscales of the Occupational Stress Inventory (Osipow & Spokane, 1992). Permission was obtained from the publisher, Psychological Assessment Resources Inc., to reproduce these scales.

The section on Job Satisfaction contained a Job Satisfaction Scale developed by Keoske, Kirk, Koeske & Rauktis (1994). These researchers were contacted and permission was given to reproduce this instrument as needed.

Conflict Management assesses the degree to which the social worker uses mediation to handle conflicts about discharge planning with their clients, clients' families and other professionals. This behavioral style of handing conflict, a stress modifier, is measured by the Integrating and Compromising subscales of the Rahim Organizational Conflict Inventory-II (Rahim, 1983). Permission was obtained from the publisher, Consulting Psychologists Press Inc., to reproduce the measures.

The section on Discharge Planning Attitudes was measured this construct through a nine item scale developed for use in this study. Variables were derived from concepts found in the social work literature on discharge planning.

The section on Job Related Feelings measured burnout through the Maslach Burnout Inventory (Maslach & Jackson, 1986). Permission was obtained from Consulting Psychologists Press Inc., to reproduce this instrument.

The Social Supports section measured the amount of social support through the Social Supports subscale of the Occupational Stress Inventory (Osipow & Spokane,

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1992). Permission was obtained from Psychological Assessment Resources Inc., to reproduce this scale.

The section on "Background Information About You" solicited information about exogenous factors such as sex, date of birth, marital status, highest degree received, and union membership. There are questions about ethnic background and the first language learned. There is also a question about whether the respondent has experienced any disturbing life events (up to three) during the past one year. Life events is conceptualized as a personal stressor in the research design.

Finally, the section on Additional Comments provided the opportunity for any written comments about the role these social workers played in mediating disagreements in discharge planning, suggestions for training that might help them better fulfill this role and any other observations about the current health care environment they wished to report.

The following (Table 2) presents an overview of the operational definitions of the constructs and the related description of measures and scales.

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Table 2. Operational Definitions of Constructs and Description of Measures and Scales

Table 2. Variables and Measures

Factor	Variable	Measurement
I. Exogenous	a. Sex	a. Male or female
	b. Age	b. Actual date of birth
	c. Marital status	c. Six categories of marital status.
	d. Ethnic background	d. Twenty-two ethnic categories.
	e. Race	e. Five racial categories.
	f. Native language	f. Thirty-two categories.
	g. Function of hospital.	g. Four types of hospital function codes.
	h. Auspice of hospital.	h. Five types of control classification codes.
	I. Education	I. Actual level of school completed and highest degree obtained.
	j. Level of primary position.	j. Staff member, supervisor/manager, administrator or other.
	k. Hours worked per week at primary position.	k. Actual hours worked per week.
	l. Years at present job.	l. Actual number of years.
	m. Years employed for this general type of work.	m. Actual number of years.
	n. Union membership.	n. Self report of being/not being a member.
II .A. Personal Stressors	o. Disturbing life event(s) over the past year.	o. A dichotomized response of Yes or No.

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II. B. **Occupational Stressors**	p. Role Overload (RO)	p. Role Overload Scale (items 1 -4 and 7-10) in the Occupational Roles Questionnaire (ORQ) of the Occupational Stress Inventory (OSI).
	q. Role Boundary (RB)	q. Role Boundary Scale (items 18, 20, 21, 26, 29, 31, 32, 36, 38, 39, 42, 46, 47) in the Occupational Roles Questionnaire (ORQ) of the Occupational Stress Inventory (OSI).
III. **Stress Modifiers**	r. Mediation: style of behavior with the client, the client's family, and professional colleagues.	r. The Integrating (IN) Scale (items 1, 4-6, 15, 21, 23, 28) and the Compromising (CO) Scale (items 9, 20, 21, 26) of the Rahim Organizational Conflict Inventory-II (ROCI-II).
	s. Coping Resources	s. Social support scale (items 21-29) of the Personal Resources Questionnaire (PRQ) in the Occupational Stress Inventory (OSI).
	t. In-service training on mediation.	t. Actual number of hours over the past year.
IV. **Outcomes**	u. Job Satisfaction	u. Koeske Job Satisfaction Scale; 14 items rating aspects of degree of satisfaction or dissatisfaction.

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v. Burnout	v. Maslach Burnout Inventory (MBI); 22 item scale to assess three aspects of the burnout syndrome; emotional exhaustion, depersonalization and lack of personal accomplishment.

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Exogenous Factors

Of the exogenous factors selected for inclusion, the following ones have been demonstrated to be systematically related to the dependant variables of job satisfaction and burnout; age, sex, marital status, level of job and education, special skills and length of employment (Maslach & Jackson, 1981; Pines, Aronson & Kafry, 1981; Siefert, Jayaratne & Chess, 1991; Wright, King & Berg, 1985; Quinn & Staines, 1979).

Many studies of job satisfaction and burnout among health and human service workers neglect to consider race and/or ethnicity in relation to job satisfaction and/or burnout (Pines & Kafry, 1978; Maslach & Jackson, 1981; Siefert, Jayarante & Chess, 1991; Elo, 1994) or to describe the race/ethnicity of their samples (Cooper & Marshall, 1978; Marriott, Sexton & Stanley, 1994; Zautra, Reynolds & Eblen, 1987). This study included race, ethnicity and native language as variables. However, it was not possible to examine how they might relate to the dependant variables: job satisfaction and burnout. This was because the majority of respondents identified their ethnic/racial origin as Caucasian (90%) and their native language as English (96%). There were not enough respondents in other categories to permit a meaningful analysis of how other races/ethnicities and/or native languages might related to the dependant variables.

This study will also included five other variables: the function of the hospital; the auspice of the hospital; whether or not over the part year any inservice and/or additional training was received on mediating discharge planning conflicts; union membership; and the percent of time spent on discharge planning.

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Data used in the analysis was obtained from variables relating to inservice and/or additional training and the percent of time spent on discharge planning. The majority (76%) of social workers were employed in general hospitals and the most frequently reported auspice was non - government, not for profit (63%). The majority (91%) were not members of a trade union. Thus, the findings of this study primarily reflect experiences of hospital social workers who were not members of a trade union and were employed in non - government, not for profit general hospitals.

The questionnaire also contained a checklist which reflected task assignments for discharge planning practice in the contemporary acute care hospital. Ten tasks were presented and included a mix of concrete service and psychosocial counseling functions. This was adapted from the Social Service Task Assignment Checklist recently used by Egan & Kadushin (1995). Their study compared the perceptions of the social work role in rural hospitals by social workers and nurses.

Finally, the questionnaire included a checklist of factors which the social workers perceived as having contributed to disagreements in discharge planning. These factors reflect findings of social work research on disagreements in discharge planning such as: unrealistic expectations about post-hospital planning by the patient and/or family; conflict between the patient and family regarding control over decision-making; emotional difficulty by the patient and/or family in adjusting to illness and ethical dilemmas caused by conflicts between the regulatory and organizational requirements of the hospital (Abramson, 1985; Abramson, Donnelly, King & Mailick, 1993; Morrow-Howell, Proctor & Mui, 1991; Donnelly & King, 1990; Donnelly & Siegel, 1993).

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Personal Stressors

Personal stressors was measured by a dichotomized response of yes or no regarding whether disturbing life events were experienced over the last year. Qualitative data was obtained by self reports which described up to three disturbing life events.

Occupational Stressors

Occupational stressors were conceptualized as role overload and role boundary. Role overload is defined as the extent to which job demands exceed resources (personal and workplace), and the extent to which an individual is able to accomplish expected work loads. This is measured by the Role Overload (RO) scale of the Occupational Stress Inventory in ten items. High scorers on the RO may describe their work load as increasing, unreasonable and unsupported by needed resources. They may describe themselves as not feeling well trained or competent for the job at hand, needing more help, and working under tight deadlines. Sample items are: "I work under tight deadlines" and "I am expected to perform tasks on my job for which I have never been trained." The alpha coefficient reported for this scale is .76 (Osipow & Spokane, 1981).

Role boundary (RB) is defined as the extent to which the individual is experiencing conflicting role demands and loyalties in the work setting. This is a ten item scale and high scorers may report feeling caught between conflicting supervisory demands and factions. They may report not feeling proud of what they do, or not having a stake in the enterprise. They may also report being unclear about authority lines and having more than one person telling them what to do. Sample items are: "My supervisor asks for one thing but really

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wants another" and "I feel caught between factions at work." The alpha coefficient reported for this scale is .77 (Ospiow & Spokane, 1981).

Stress Modifiers

Coping resources were measured by the nine-item Social Support (SS) scale of the Occupational Stress Inventory (OSI). Social support is defined as the extent to which the individual feels support and help from those around him/her. High scorers may report feeling that there is at least one person they can count on and who values/loves them. They may report having sympathetic people to talk to about work problems and report having help to do important things and/or things around the house. They may also report feeling close to another individual. Sample items are: "There is at least one sympathetic person with whom I can discuss my work problems" and "I feel loved." The alpha coefficient reported for this scale is .76 (Osipow & Spokane, 1981).

In-service training and/or additional training received over the past year in mediating discharge planning conflicts was measured by a dichotomized response of yes or no. Respondents were also asked to provide the number of hours received. This was useful, adjunct information.

Conflict is defined as an "interactive state" manifested by disagreement, differences or incompatibility within or between social entities; i.e., an individual, group, organization, etc. (Rahim, 1983).

Mediation is defined as intervention with respect to conflict or the negotiation by an acceptable and bias-free third party. This third party assists disputing parties in

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voluntarily reaching their own mutually acceptable settlement of issues by coordinating activities and teaching bargaining effectiveness.

Mediation is an extension of the negotiating process. Bargaining and use of a mediator will contribute new variables and dynamics to the interaction of the disputants. Without negotiation, however, there can be no mediation. Mediation is also problem based and aimed at a mutually agreeable behavioral outcome. Personal changes are a secondary outcome of agreement seeking (Moore, 1986; Parsons, 1991).

The behavioral style of conflict mediation is measured by two scales of the Rahim Organizational Conflict Inventory-II (ROCI-II); Integrating (IN) and Compromising (CO) (Rahim, 1983).

Integrating is a seven item scale measuring exchange of information and examination of differences required to reach a solution acceptable to both parties. It measures problem solving that may lead to creative solutions. Sample items are: "I collaborate with my clients/the client's family/professional colleagues to come up with decisions acceptable to us" and "I try to integrate my ideas with those of my clients/the client's family/professional colleagues to come up with a decision jointly." The alpha reported for the Integrating Scale is .77 (Rahim, 1983).

Compromising is a four item scale which reflects a style that is intermediate in concern for both self and others. It involves sharing whereby both parties give up something to make a mutually acceptable decision. It may mean splitting the difference, exchanging concessions, or seeking a middle-ground position. Sample items are "I use give-and-take so that a compromise can be made" and "I negotiate with my clients/the

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client's family/professional colleagues so that a compromise can be reached." The alpha reported for this scale is .72 (Rahim, 1983).

Pretest

The questionnaire was pretested with 10 volunteer masters level social workers who were professional associates of the Principal Investor. They all were currently practicing in an acute care hospital on inpatient units. They all were designated as the primary discharge planner for their service.

There were a range of responses dispersed across the items. No respondent answered in the same way and all provided helpful suggestions. For example, in the Discharge Planning Interventions measure several respondents felt that it was confusing to include both items: “helping a patient cope with illness” and “counseling an ill patient.” The first item was also felt to be vague, therefore, it was not included in the final questionnaire. The second item was retained and used in the final questionnaire.

Another helpful suggestion from this pretest was reflected in the scale on Discharge Planning Attitudes. Feedback from the respondents resulted in the inclusion of two items in the final questionnaire. They were: “I have to regularly stay late to complete all the tasks associated with discharge planning” and “I wish other professional staff had a better understanding and/or appreciation of my work in discharge planning.” Finally, the time frame for receiving inservice and/or additional training to mediate discharge planning conflicts was expanded from six months to one year. This was a result of only respondent reporting training over the past six months thereby suggesting that this original time frame was too short.

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The questionnaire took each respondent about 35 minutes to complete. This included time for written comments and suggestions to the Principal Investigator about the questionnaire. All of the respondents spontaneously reported having enjoyed filling out the questionnaire as it was easy to follow, clearly laid out and highly relevant to their current health care social work position.

Outcomes

Job satisfaction was measured by an eighteen item instrument, the Job Satisfaction Scale. This is a measure of both intrinsic qualities of the work role (e.g., working with clients, opportunities for really helping people and your feelings of success as a professional) and organizational job satisfaction (e.g., quality of supervision received, amount of authority you have been given to do your job and clarity of guidelines for doing your job). The alphas for the total Job Satisfaction Scale are reported to range from .83 to .91 and reliabilities of the intrinsic and organizational satisfaction subscales ranged from .85 to .90 and .78 to .90, respectively (Koeske, Kirk, Koeske & Rauktis, 1994).

The Job Satisfaction Scale intentionally excludes any items which make reference to job pressure or stress. While job pressure or stress are phenomena that effect job satisfaction, they are not attributes of the job itself. The job satisfaction construct is distinct from constructs such as burnout, job commitment or intention to quit the job (Koeske, Kirk, Koeske & Rauktis, 1994).

Burnout is a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who do "people work" of some kind. A key aspect of the burnout syndrome is increased feelings of emotional

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exhaustion; as emotional resources as depleted, workers feel they are no longer able to give of themselves at a psychological level. The development of depersonalization is another aspect of burnout. Depersonalization is the negative, cynical and dehumanizing perceptions about clients. The development of depersonalization appears related to the experience of emotional exhaustion. The third aspect of the burnout syndrome is reduced personal accomplishments. This refers to the tendency to evaluate oneself negatively, particularly with regard to one's work with clients. Workers may feel unhappy about themselves and dissatisfied with their accomplishments on the job (Maslach, 1986; Maslach & Jackson, 1981; Cherniss, 1980).

Burnout was measured by the twenty-two item Maslach Burnout Inventory (MBI) which is designed to assess the three aspects of the burnout syndrome: emotional exhaustion, depersonalization and lack of personal accomplishment. Each aspect is measured by a separate subscale with burnout conceptualized as a continuous variable ranging from low to high degrees of experienced feeling. The internal consistency of the scales was estimated by Cronbach's coefficient alpha. The authors report the reliability coefficients for the subscales as follows: .90 for Emotional Exhaustion; .79 for Depersonalization and .71 for Personal Accomplishment (Maslach, 1986).

Data analysis

Overview

Once the data were collected, the research questions were addressed through a statistical analysis of the data. The data were analyzed using techniques of the t-ratio and F-ratio; r and R were also employed.

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The t - ratio is a comparison of differences between means of defined groups, e.g. "men and women differ in their preference for styles of handling conflict." For each group, the mean of the variable is computed, as is the variance of the scores in that group. From the variance, and the sample size, one computes the standard error of the mean, a statistic indicating the sampling variability of the means (Smith, 1990).

The correlation coefficient (r) indicates the strength of a relationship between two measures. Whether it may be considered "significantly greater than 0" may be established by computing the standard error and referring to the same t - ratio as before (Craft, 1990).

The F - ratio is used when more than two groups are being compared or when more than two relations are to be investigated simultaneously. Numerically, F is closely related to the square of t; the variance ratio indicates whether the magnitude of the differences among the means are greater than one would expect if all three means were based on random samples (Grinnell, 1988).

The Regression and multiple-regression techniques are used to depict the strength of relations involving more than three variables. R and F are sometimes used where only two measures or groups are involved in order to present data in a parallel fashion (Grinnell, 1988).

Finally, because the same social workers were used repeatedly to get the means and correlations pertaining to different measures, it is important to note The Bonferroni Principle. When conducting an experiment, an attempt is made to select variables reflecting certain relations that are not random, and then look at correlations or differences between means to see whether the obtained values are unlikely in terms of the tabulated

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probabilities. If so, the hypothesis of "no difference " is rejected and the truth of the non random hypothesis is claimed. According to the rules, we are allowed to enter the table only once for each sample. Using the same persons repeatedly to get means and correlations pertaining to different measures is inconsistent with the initial assumption under which the tables were constructed and so some adjustment must be made. In general, if two measures are shown to be correlated in a sample, then other measures made on the same sample are likely to be correlated with each other as well (Guilford & Fruchter, 1973).

The Bonferroni adjustment used in this study is to adjust the probability level that determines whether the hypothesis is rejected; when more than one measure is used on the same sample, the probability of rejection is changed so that rejection is less likely than if one entered the table only once for each sample. (Guilford & Fruchter, 1973).

In the present study, it was decided to use the basic Type 1 error of 5% and to consider that twenty entries would be made into the table, based on the statements of hypotheses. Thus, the "experiment-wise" Type 1 error is still 5% but the individual tests of hypothesis are referred to a probability of occurrence of .0025, not .05. Fortunately, the sample size here is large enough so that the adjustment makes little real difference if relations are large enough to be considered important. When the phrase "Bonferroni adjustment made" appears, it means that the observed statistical outcome is referred to a critical value corresponding to a probability of occurrence that is .0025; a very extreme and unlikely occurrence if the phenomena were in fact random(Guilford & Fruchter, 1973).

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Scoring and scaling the responses

In the inventories adapted for this study, many of the statements are set up so that a high numerical value means a great deal of a particular phenomenon; other scales are set so that the opposite is true. For example, the scales which measure Role Overload and Role Boundary have high scores which mean, respectively, maximum reporting of overloading events and concern about Role Boundaries. In contrast, the scales which measure Integrating and Compromising styles of conflict resolution have high scores which mean, respectively, non - use of integrative and compromising styles of behavior as strategies for resolving conflicts. Therefore, it is useful to closely examine the directionality of the scales and note whether the respondents are "high" or "low" on the scale.

For each of the measures in this study, responses to items were given a numerical value determined by the printed scale to which the subjects responded; these values were summed. Because of the differences in wording, some sums indicated a lot of the measure, others a little. For many of the measures, a few respondents chose not to respond to certain items. This problem was really quite small but it was necessary to compute a "pro-rated" score for each person who failed to respond to any item.

The "pro rated" scores were computed by summing the item values and then dividing them by the number of items to which the social worker responded. These pro-rated values were then placed in frequency distributions, and these in turn were inspected for skewness. Skewness is based on the sample size and on the number of items in the scale. The skew is positive if the tail of the distribution is toward the high numbers on the

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scale. It is negative if the tail is toward the low values. Positive skew indicates that most social workers responded in the lower values of the scale, while negative skew indicates a preference for higher scale values.

After the scores were summed from the item responses to create scale scores, the reliability of the summed scores was computed. The procedure used was the Cronbach's Alpha coefficient, based on the comparison of the average variance in item responses and the variance in scale responses. This method of computing alpha tends to underestimate the true reliability when scales have only a few items, and to overestimate when the item scores and/or scale scores are badly skewed. It is, however, one of the best available methods for estimated scale reliability (Guilford & Fruchter, 1973).

Of the eleven measures involved in tests of hypotheses in this study, six were sufficiently skewed to need adjustment to meet more nearly the normal assumption underlying the computation and interpretation of correlations and differences between means. The adjustment made is called the Stanine transformation. This is a procedure for relating standard score values in the normal distribution to percentiles in the normal distribution. The six measures needing the adjustment due to extreme skewness were: Role Boundary, Integrating Style of Conflict Resolution, Compromising Style of Conflict Resolution, Social Support, Burnout and Attitude Toward Discharge Planning

Description of the sample

Sex, age, marital status, ethnic/racial origin, native language, educational level

The majority of the sample were women (84%). For the entire sample, the majority were married (63%) with others reporting their marital status as follows: never married

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(16%), divorced (15%), widowed (4%) and separated (2%). The average age for women was 50 and the average age for men was 53.

Most social workers in this sample identified their ethnic/racial origin as Caucasian (93%) followed by African American (3%), Asian or Pacific Islander (2%) and mixed heritage (1%). Those who identified as American Indian were a very small percentage (.3%) as was the case for Chicano/Mexican American (.3%) and Puerto Ricans (.3%).

The overwhelming majority (96%) reported English as their native language or the first language learned if more than one was spoken. Small percentages of social workers indicated other native languages which were: Hungarian (1%), Asian Indian (1%), Spanish (1%), Armenian (.3%), Chinese (.3%), French (.3%) German (.3%) Korean (.3) and Philippine languages (.3%).

The most frequently obtained highest degree was a Master of Social Work (94%) with the Bachelor of Social Work reported as the second (3%). The highest degrees obtained for the rest of the sample were: Doctor of Philosophy (2%), Doctor of Social Work (.5%) and other degrees; what type were not indicated (.5%).

The majority of social workers (60%) did not report over the past year having received in service and/or additional training in mediating discharge planning conflicts. Of those who did report training over the past year (40%), the average number of hours was three.

Work setting

Most social workers in this study worked in a general hospital (76%) followed by rehabilitation (9%), special, e.g. pediatrics, cancer (9%), psychiatric (3%) and chronic

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disease (3%). The auspice of most of these hospitals was non - government, not for profit (63%) with the other auspices as follows: government, non federal (13%), investor owned (13%) and government, federal (10%).

Within the hospital, most social workers reported their primary job assignments were on inpatient medical/surgical services (52%) with others on a range of inpatient services; rehabilitation (12%), pediatrics (11%), psychiatry (7%) and ob - gyn (5%). Some of the social workers reported their primary assignment to be in other areas of health care such as hospice and home health care. The majority (64%) spent 40 hours per week in their primary job assignment and the average number of years in their current position was eleven (SD = 8).

Finally, the majority of social workers were staff social workers (86%) with the remainder employed as supervisors (11%) and administrators (3%). The majority (91%) were not members of a trade union.

Discharge planning: amount of time, frequency of interventions, factors contributing to disagreements

All of the social workers were involved in providing discharge planning services (see Table 3). However, there was a wide range in the amount of time social workers reported they primarily spent in this activity. The smallest percentage of social workers were at the either end of the spectrum; 23% reported spending one quarter of their time or less and 19% reported spending three quarters to all of their time on discharge planning. There was an equal percent reporting that discharge planning activities accounted for one quarter to one half of their time (29%) and one half to three quarters of their time (29%).

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Table 3: Time Spent On Discharge Planning

Percent of time spent	n	%
25% or less	82	23
26% to 50%	102	29
51% to 75%	103	29
76% to 100%	66	19

Respondents were also asked to select which factors contributed to disagreements in discharge planning between the key figures of patient, patients' family and/or hospital staff (see Table 3). Underscoring the many complex factors which converge to create these conflicts, is that all of them were frequently reported as contributing.

There were two major factors reported as having contributed to disagreements in discharge planning: unrealistic expectations about discharge planning and difficulty adjusting to illness/disability. The two most frequently reported factors were: unrealistic expectations about discharge planning by the patients' family/significant other (86%) and the patients' difficulty adjusting to illness/disability (81%). These were followed by: emotional difficulty adjusting to illness/disability by the family/significant other (79%); misunderstandings among the patient, family and/or hospital staff regarding the length of stay (77%) and unrealistic expectations about discharge planning by the patient (74%). Of interest, is that the least frequently reported factors contributing to discharge planning conflict were those having to do with ethical dilemmas (see Table 4).

Social workers were asked to indicate how often they used various discharge planning interventions. Included were both concrete service provision and counseling related activities (see Table 5).

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Table 4: Social Workers' Report Of Factors Contributing To Disagreements in Discharge Planning

Factor	%
Unrealistic expectations about discharge planning by the patients' family/ significant other	86
Emotional difficulty adjusting to illness /disability by patient	81
Emotional difficulty adjusting to illness/disability by the patients' family/significant other	79
Misunderstanding among the patient, family and/or hospital staff regarding the length of stay	77
Unrealistic expectations about discharge planning by patient	74
Conflict between the patient, family and /or hospital staff regarding the type and availability of services for discharge planning	72
Conflict between the patient, family and/or hospital regarding the type and availability of services for post-hospital care	72
Conflict between the patient and family about decision making power for discharge planning	48
Ethical dilemmas caused by conflicts between the patients' rights and the regulatory and organizational requirements of the hospital	44
Ethical dilemmas caused by conflicts between the regulatory and organizational requirements of the hospital	38

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Table 5: **Social Workers' Report of How Often They Use Discharge Planning Interventions**

Intervention	Frequency of Use by Percent	
	Every Day	Few Times Weekly
Assessing psycho social functioning of patient and/or family	74	15
Helping a patient/family plan for discharge	60	21
Assess impact of illness on family/ significant other	56	24
Counsel an ill patient	47	25
Counsel a family member about patient's illness	43	34
Assess the patient's need for home health care	34	30
Help patient/family understand insurance costs	27	30
Arrange for post - hospital nursing home placement	11	19

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For the interventions provided in this questionnaire, most of the social workers reported using their assessment skills every day (74%) and helping a patient/family plan for discharge (60%). The opportunities to provide counseling to either patients (47%) and families (43%) every day were reported as much less frequent.

This checklist was limited in the amount of information it could provide due to the relatively few categories of discharge planning interventions and the lack of measures for determining the relative importance of each intervention to discharge planning. However, regarding the frequency of use, these findings echo those of Kadushin & Kulys (1993). In their study, social workers in acute care hospitals were asked to estimate the time they spent on 73 discharge planning tasks. In mean expenditure of time, the counseling category ranked behind assessment. As well, the assessment tasks were found to be both some of the most time consuming and important activities for social work discharge planners. Both assessment and counseling were identified as core activities of discharge planning.

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CHAPTER 4

RESULTS OF THE STUDY

Overview

In this chapter, results of the six research questions are discussed. It should be noted that the six research questions, based upon the relevant literature, could not be tested directly. They were translated into testable statistical hypotheses which were logically derived from the research questions (Craft, 1990). However, for purposes of clarity only the research questions will be presented.

The first research question addresses social workers' attitudes towards discharge planning and the relationships with job satisfaction and burnout. The second research question is concerned with styles of handling conflict to mediate discharge planning conflicts and the relationship to gender. The third research question looks at whether a preference for using an integrating and/or compromising style of handling conflicts to mediate conflicts in discharge planning effects job satisfaction. The fourth research question concerns the effects of occupational stressors, personal stressors and stress modifiers on job satisfaction and burnout. The fifth research question looks at the relationships of role overload and training in mediating conflicts on job satisfaction. Finally, the sixth research question concerns the amount of social support reported by social workers and whether this mediates the impact of role boundary concerns on the frequency of symptoms of burnout.

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Research Question 1

Research question 1 is concerned with social workers' Attitudes toward Discharge Planning and the relationships with Job Satisfaction and Burnout.

Research Question 1: Positive Attitudes toward Discharge Planning will be positively related to Job Satisfaction and negatively related to Burnout.

Measures Used

The measure used to determine Attitude toward Discharge Planning (ATST) was a nine item scale, Discharge Planning Attitudes, developed for use in this study. Social workers were asked to rate the one response which best described their attitude for the nine statements about discharge planning.

This is scored so that a high score reflects a positive attitude toward discharge planning. The mean response for the prorated scores in this study was 2.75 (cue; 1 strongly agree; 3 undecided; 5 strongly disagree).

Job Satisfaction (JSAT) was measured by the eighteen item Keoske Job Satisfaction Scale (Keoske, Kirk, Koeske & Rauktis, 1994) which asked the social workers to rate aspects of their work on an eleven point scale according to the degree of satisfaction or dissatisfaction it provided them. Items included "the amount of authority you have been given to do your job" and "the recognition given your work by your supervisor."

A high score indicates the level of satisfaction with the job; the higher the score, the greater the level of satisfaction. The mean response of the prorated scores was 7.52

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(cue: 1 very dissatisfied; 11 very satisfied). The alpha reliability for the prorated scores in this study was .92.

Burnout (BURN) was measured using the twenty-two item Maslach Burnout Inventory (Maslach & Jackson, 1981, 1986) which asked the social workers to rate how they feel about their job. They were asked to rate the items on a six point scale which ranged from experiencing the given item a few times a year or less to every day. The Maslach Burnout Inventory has sub scales which capture the salient aspects of the burnout syndrome; emotional exhaustion, depersonalization and dissatisfaction with accomplishments on the job. Statements of job-related feelings included: "I feel emotionally drained from my work," I feel I treat some clients as if they were impersonal objects" and "In my work, I deal with emotional problems very calmly."

A high score reflects a greater frequency of symptoms of Burnout. The mean response of the prorated scores was 1.72 (cue: 0 never; 1 a few times a year or less; 3 a few times a month; 5 every day). The Alpha reliability for the prorated scores in this study was .86.

Procedures Used and Results Obtained

The hypothesis was analyzed through the use of correlational analyzes (see Table 6) with the criterion of Attitude toward Discharge Planning (ATST) in order to determine the relative contributions of the two predictors: Job Satisfaction (JSAT) and Burnout (BUST).

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TABLE 6: Values of Intercorrelations for Attitude toward Discharge Planning (ATST), Job Satisfaction (JSAT) and Burnout (BUST)

r	ATST	JSAT	BUST
JSAT	.44	1.00	-.53
BUST	-.41	-.53	1.00

Simple correlation shows that both hypothesized relationships are true; Attitude toward Discharge Planning (ATST) and Job Satisfaction (JSAT), both scored so that a high numerical score is positive on the scale, have a positive correlation ($r = .44$, $p < .05$). The scale for Burnout (BURN) is reversed in the scoring so that a low score indicates a high likelihood of Burnout ($r = -.41$, $p < .05$). Therefore, as was hypothesized in the research question, those social workers who have positive Attitudes towards Discharge Planning will report greater Job Satisfaction and less frequent occurrences of Burnout. In addition, Job Satisfaction and Burnout are also highly correlated with each other ($r = -.53$, $p < .05$). This means that a high degree of Burnout is related to low Job Satisfaction.

Discussion

Results of this study highlight the importance of looking at social worker's Attitudes toward Discharge Planning when predicting their level of Job Satisfaction and Burnout. This study has found that social workers who feel positively towards discharge planning will also have positive reports of Job Satisfaction and report less symptoms of Burnout. Given these relationships, it also possible to say that the converse will occur. Social workers who report frequent symptoms of Burnout will have a more negative Attitude toward Discharge Planning and report low levels of Job Satisfaction.

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Regarding positive Attitudes towards Discharge Planning, the majority of social workers (58%) agreed that discharge planning was very rewarding however they would rather not be in a job that did not involve discharge planning (55%). Factors contributing to positive Attitudes toward Discharge Planning and Job Satisfaction are suggested by social workers' responses to the Attitude toward Discharge Planning Scale (see Table 7) as well as their written comments.

It is suggested that one reason for positive Attitudes towards Discharge Planning (which then has a positive influence on levels of Job Satisfaction and decreases the frequency of Burnout), is that social workers were able to utilize their special skills and expertise. Being able to use special training on the job has been consistently and highly related to overall job satisfaction (Marriot, Sexton & Staley, 1994; Locke, 1976; Jayaratne & Chess, 1984).

Positive attitudes towards discharge planning and job satisfaction were reflected in the following written comments by social workers who used their skills and training. These comments suggest that these social workers believed that discharge planning required special skills and was a professional function. One social work supervisor wrote, "I see discharge planning as crisis counseling and have always believed it demands a high level of clinical skills to assess issues in an ethical and competent manner no matter if the setting is rehabilitation, orthopaedics, medicine/surgery, hospice etc."

Another social worker related, " I enjoy my work as a clinical social worker, the setting here allows me to use my cumulative knowledge and skills to serve the patient population at this medical center. Also, I enjoy interacting with each new group of

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students, interns, residents and attending medical staff. Since this hospital is a teaching hospital, I like to share my knowledge with them to help them become all they can be. Also, it is rewarding to help the patients become all they can be."

Deriving intrinsic rewards from work has also been found to positively influence job satisfaction (Jayaratne & Chess, 1983; Siefert et al. 1991; Kadushin & Kulys, 1995). Some social workers wrote comments expressing feelings of satisfaction which arose from the intrinsic reward of having gratitude expressed by patients, families and other staff about their help with discharge planning. One social worker stated, "I love medical social work despite the great stresses of the changing health care industry. I am totally committed to my (Catholic) Hospital and my patients. I re-energize myself every time I am able to make a good placement for a patient. I also get a lot of support and appreciation from patients, families, doctors and most of the long time nursing staff."

As was stated earlier, confirmation of this research hypothesis also suggests that converse relationships also occur; social workers who report frequent symptoms of Burnout have a more negative Attitude toward Discharge Planning and report a low level of Job Satisfaction. Suggestions for why these social workers experienced Burnout are also implied by responses to the Attitude toward Discharge Planning Scale (see Table 7). and written comments.

Many social workers (73%) found discharge planning to be very stressful and felt there was not enough time to complete all the tasks associated with discharge planning (65%) (see Table 7). Many social workers (40%) also reported having to regularly stay late to complete all the tasks associated with discharge planning. As well, the majority of

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social workers (70%) enjoyed individual and/or family counseling more than discharge planning and wished that other professional staff had a better understanding and/or appreciation of their work.

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Table 7: Attitudes towards Discharge Planning: Social Workers' Responses by Percentage (N = 355)

	Agree	Undecided	Disagree
Discharge planning is very rewarding	58%	16%	26%
I enjoy individual and/or family counseling more than discharge planning	70%	15%	15%
Discharge planning is the most important thing a hospital social worker does	38%	17%	45%
There is not enough time to complete all the discharge planning tasks	65%	14%	21%
Discharge planning is very stressful	73%	11%	16%
Discharge planning is a real burden for me	21%	18%	61%
Rather be in a job where I did not have to do discharge planning	27%	18%	55%
Have to regularly stay late to complete the work related to discharge planning	40%	9%	53%
Wish other professional staff had a better under-standing and/or appreciation of my work	70%	11%	20%

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The following comments reflect these concerns about and reactions to the current health care environment. One social worker wrote," I love my job as a hospital social worker but I'm afraid my job is on the way out. Case managers are the new buzz words - we hear they are close at hand to take our jobs. And I'll be DAMNED if I'll teach a nurse how to do my job. They can figure out on their own how to do a nursing home placement. Our job is so multifaceted and complex. Every patient is so unique and there are situations we must solve that only occur once every 2-3 years and our knowledge is cumulative. By the way, in today's financial climate most discharge planning issues are promptly solved out of our hands by Utilization Review teams issuing a Medicare Letter of Denial."

Similar sentiments were echoed by another social worker who commented, "Nearing the end of 30 years of hospital social work I despair for the profession in the future. The early days of Medicare/Medicaid were generous and fun. We could direct patients/families to resources where actual help could be provided. There was time and encouragement for us to be true advocates for out patients. Now we find ourselves spending precious time providing information to insurance case managers in other time zones who determine what the patient may or may not receive in benefits or post hospital care. Gone are the days when we could negotiate freebies for our indigent patients on the basis of past referrals. No longer are families given the opportunity to explore long term facilities in this get 'em out atmosphere."

Finally, another observed," Discharge planning has changed a good deal in the recent years, especially the last two. We have less support from administration and less time to give to clients. The result is the relationship between the social worker and the

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client has suffered so much. Also, a lot of what is accomplished in the hospital falls apart within weeks of discharge. I fear this will result in less time spent with clients and cause even more poor results for them. It could take a long time before anyone connects the two; the poor results with the decrease in services and service time with the clients.

It has been observed that if helping professionals do not have access to resources needed to meet the requirements of the job, the potential for burnout is high. (Cherniss, 1980) . The externally driven constraints on service provision, wrought by cutbacks in entitlements and the parameters imposed by managed care, may impede social workers from providing their ideal level of assistance or using their special skills and expertise. These situations may cause emotional distress for human service workers who often have a strong psychological investment in their work and value themselves most through being sympathetic, understanding, unselfish and helpful to others (Pines & Kafry, 1978; Siefert, Jayaratne & Chess, 1986, Cherniss, 1980).

It is likely that the very attributes which make human service workers qualified for the job also make failure to provide optimal assistance, because of factors beyond the worker's control, to be felt as a lack of personal competence (Ratliff, 1988; Soderfelt, Soderfelt & Lars- Erick Warg, 1995). As one social worker wrote, " I empathize with the patients and families and try to alleviate the hurt. And when you are telling a spouse she is going to have to use hard earned assets on her husband's nursing home—it is painful. So, I am drained most of the time."

In conclusion, there are many factors in the current health care environment which influence negative Attitudes towards Discharge Planning reported in this study and

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expressed in the comments above. These include: shorter lengths of hospital stay , fewer options for aftercare (Fein, 1995), heavier caseloads with more complex and demanding cases (Siefert, Jayaratne & Chess, 1991), increased competition between social work and nursing for the primary role as discharge planner (Ingelhart, 1990; Freeman, 1992; Cowles & Lefcowitz, 1992; Kulys & Davis, 1987; Egan & Kadushin, 1995), managed care and the downsizing of many hospitals (Globerman, Davies & Walsh, 1996; Berger, Cayner, Jensen, Mizrahi, Scesny & Trachtenberg, 1996; Ross, 1993; Cornelius, 1994; Cowles & Lefcowitz, 1992). Their overwhelming impact may engender feelings of helplessness in social workers who persevere in their efforts to provide discharge planning services. A sense of helplessness is one of the underlying causes of burnout (Cherniss, 1980).

Implications for future research

Further research is needed on how social workers struggle to reconcile their conflicted Attitudes towards Discharge Planning as reported in this study (see Table 8). For example, 55% did not prefer to be in jobs that did not involve discharge planning and 58% found discharge planning to be very rewarding, yet 73% found discharge planning to be very stressful and 70% preferred individual and/or family counseling more than discharge planning. Such an investigation might include information on coping strategies (including spiritual/religious beliefs) and the impact of managed care on the opportunity to use special skills/expertise and derive intrinsic rewards from hospital social work.

As well, it would be valuable to gain further knowledge (i.e. are they in higher status or lower status jobs) about those social workers who report less frequent symptoms of burnout and higher levels of Job Satisfaction despite the current changes in health care.

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Understanding how these individuals cope with occupational stress would benefit all types of professionals in health care and allow social work to take a leadership role in staving off the devastating toll of burnout.

Research Question 2

Research question 2 is concerned with preferences for styles of handling conflict and the relationship to gender.

Research Question 2: Responses of men and women will differ with respect to behavioral styles of mediating conflicts which may arise in discharge planning, but the direction of the preference is not clear.

Measures Used

The measures used for the behavioral style of mediating conflicts which may arise in discharge planning are two scales of the Rahim Organizational Conflict Inventory - II (ROCI - II) ; Integrating (IN) and Compromising (CO) (Rahim, 1983).

Integrating (INSUM) was a seven item scale measuring exchange of information and examination of differences required to reach a solution acceptable to both parties. It measured problem solving that may lead to creative solutions. A sample item is " I try to investigate an issue with other professional staff to try and find a solution acceptable to us."

A low score indicates a preference for using an Integrative style as a strategy for resolving conflicts which may arise in discharge planning. The mean of the prorated scores for this study was 1.87 (cue: 1 strongly agree; 3 undecided; 5 strongly disagree). The Alpha reliability for the prorated scores in this study was .92.

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Compromising (COSUM) was a four item scale which reflected a behavioral style which was intermediate in concern for both the self and others. It may involve splitting the difference, exchanging concessions or seeking a middle ground position . A sample item is " I use give and take so that a compromise can be made."

A low score indicates a preference for using a Compromising style as a strategy for resolving conflicts which may arise in discharge planning. The mean response for the prorated scores in this study was 2.80 (cue: 1 strongly agree; 5 strongly disagree). The Alpha reliability for the prorated scores in this study was .45 indicating lower reliability than the earlier scales.

Both Integrating and Compromising Styles of Handling Conflict were repeated in three sets of questions which asked the respondents to indicate how they would handle conflicts which may arise in discharge planning with other professional staff, client's families and clients. There were a total of eleven questions which included both the Integrating and Compromising Scales. Instructions were given to reply with a response that was most characteristic of one's behavior in a situation of conflict involving discharge planning. There was five point scale which had the following responses: Strongly Agree (SA), Agree (A), Undecided (UD), Disagree (D) and Strongly Disagree (SD). From this, six measures of conflict resolution were devised: Integrative with Coworkers (INCOST), with Families (INFAST), and with Clients (INCLST); and Compromising with Coworkers (COCOST), Families (COFAST) and Clients (COCLST).

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Procedures used and results obtained

This hypothesis was tested using a two- tailed t test of the correlation coefficient (p = .05). Results of the analysis of the six measures of behavioral Style of Handing Conflicts in discharge planning for male and female social workers are as follows (see Table 8). The results show that the differences between means are not statistically significant and clearly there are no differences in Styles of Handling Conflict which are attributable to gender.

Table 8: Means And t - ratios For Six Measures of Styles of Handling Conflict For Men and Women Social Workers

	MEN (n = 54)		WOMEN (n = 277)			
	Mean	SD	Mean	SD	t	COMMENT
INSUM	14.05	6.08	14.68	5.71	-.42	NSD
INCOST	5.29	2.12	4.94	2.15	1.11	NSD
INFAST	5.09	2.19	4.94	2.06	.51	NSD
INCLST	4.72	2.34	4.81	2.25	-.24	NSD
COSUM	15.46	5.15	15.68	5.49	-.26	NSD
COCOST	6.07	1.94	5.67	2.38	1.19	NSD
COFAST	4.67	1.97	4.91	1.99	-.86	NSD
COCLST	4.83	2.04	5.11	2.14	-.87	NSD

Discussion

This study has found that there are no differences in Styles of Handling Conflicts which may arise in discharge planning attributable to gender. This finding should be viewed in the larger context of prior research which concerns the negotiating behaviors of men and women. Due to several decades of change in gender roles, this body of research is often confusing and inconclusive regarding the negotiating behaviors of men and

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women. A number of studies do find clear cut differences in styles, while others do not (Hocker & Wilmont, 1995).

Although sex appears to be an inadequate predictor of one's choice of conflict management style (Berryman-Fink & Brunner, 1987), results from a variety of these studies suggest that on balance, women do have greater preferences for integrative, compromising and tactful strategies; these take the partner's interests into consideration. Results from these same studies suggest that men have greater preferences for competitive, unyielding and aggressive strategies; these protect the self at the expense of the partner (Rahim, 1983; Miller, 1991; Warfel, 1984; Hocker & Wilmont, 1995).

As well, because women have also typically been viewed as less powerful and more concerned with politeness than men, it has been suggested that women are more likely to employ indirect, manipulative strategies. Men tend to employ direct, rational strategies. However, it is interesting to note that when differences in gender - linked resources (power) and self - confidence are controlled such sex differences in strategy use are diminished. Thus, direct and indirect strategy use may be related more to issues of power and politeness than of gender (Steil & Hillman, 1993; Noller, 1993).

It is further suggested that if men and woman also use language differently, this may be a reflection of people's active roles . Some argue that society allocates these adult roles on the basis of sex and traditional occupational segregation may have generated a linguistic dichotomy along gender lines; i.e. males' speech tended to become assertive and females' speech supportive, in line with their positions in the world. (Warfel, 1984; Lackoff, 1975; Miller, 1991).

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Given that prior research has suggested that conflict management styles and related use of language may differ for men and women, it is of interest that this study found no statistically significant differences in the use of Integrating and Compromising Style of Handling Conflict between men and women social workers (see Table 8). The importance of role and situation in explaining behavior (Sidertis, Johannsen & Fadden, 1985) may help explain this finding.

Men and women social workers may both utilize Integrating and Compromising Styles of Handling Conflict because they are enacting the same occupational role. Both men and women were socialized into this role through training they received in schools of social work. It has been suggested that one factor which plays an important role in the use of language and style of handling conflict is education; a venue where socialization into a profession and the learning of relevant skills occurs. (Simkins-Bullock & Wildman, 1991).

In this study, all men and women social workers had degrees in social work. Through their training in school of social work, it is suggested that both genders were exposed to similar professional socialization and training. Given this, the preference of both men and women social workers to use Integrative and Compromising Styles may support prior research that factors other than gender, such as education, play a major role in both the use of language and conflict management.

The selection of strategies in conflict management have also been suggested to derive from issues of power, rather than gender (Hocker & Wilmont 1995; Noller, 1993; Steil & Hillman, 1993) . Both men and women social workers have the same degree of

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power in a hospital; power which is derived from their similar occupational role rather then their gender.

Hospitals are host institutions to social workers where other professions, such as physicians, define and dominate the setting (Dane & Simon, 1991). As resident guests, both men and women social workers may lack the formal authority to force decisions on parties who are experiencing disagreements in discharge planning. Both men and women social workers' behavioral styles of handling disagreements in discharge planning may reflect this lack of formal authority to impose decisions or orders on other professional staff, clients or clients' families. Therefore, both men and women social workers may intervene in discharge planning disputes with non authoritative behavioral styles (Integrating and Compromising) because these are the resources available to them in a host setting.

Finally, it should be noted that styles of handling conflicts may be influenced by the gender of the person with whom the conflict is experienced (Hocker & Wilmont, 1995). One study has found that regardless of gender, all of the subjects were more likely to report using an accommodating style if the other person is female. (Berryman-Fine & Brunner, 1987). This study did not ask respondents to indicate the gender of the other professional staff, clients and clients' families involved in the discharge planning disagreements. Perhaps doing so would have yielded additional and/or different results.

Implications for future research

Clearly, the issue of gender influences on styles of handling conflict is complex. However, it is clearly relevant for a profession which has traditionally been peopled by

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women ; as was reflected in this national survey where 84% of the respondents were female. Social workers, typically female, often practice in settings such as hospitals, which are predominantly male in inspiration and composition (Dane & Simon, 1991).

Although this study did not find that there were differences in Style of Handling Conflict attributable to gender, further research is needed to understand the role that socialization into the profession of social work may play in this finding. Related to this are questions about the influence of the setting (i.e host setting) and professional training on how social workers' respond to disagreements in discharge planning.

As well, it would be useful to gather information on how social workers involved with disagreements in discharge planning would respond if the other person were male or female. Such information would allow social workers to gain awareness of how gender may influence their selection of behavioral style in these situations.

Finally, future research might explore the impact of organizational hierarchy and power differentials on social workers' styles of handling discharge planning conflicts. As discussed earlier, this study suggests that these factors play an important role in determining the behavioral style social workers use .

Research Question 3

Research question 3 looks at whether a preference for using an Integrating and/or Compromising Style for mediating conflicts in discharge planning is related to Job Satisfaction.

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Research Question 3: The preference for using an Integrating or Compromising Style for mediating conflicts in discharge planning with professional staff, clients or client's families will be related to Job Satisfaction.

Measures Used

The measures used for the behavioral style of mediating conflicts which may arise in discharge planning are two scales of the Rahim Organizational Conflict Inventory (ROCI - II); Integrating (IN) and Compromising (CO) (Rahim, 1983). Six measures of conflict resolution were devised: Integrating with Coworkers (INCOST), with Families (INFAST) and with Clients (INCLST); and Compromising with Coworkers (COCOST), Families (COFAST) and Clients (COCLST).

Job Satisfaction (JSAT) was measured as discussed in prior hypotheses, by the eighteen item Keoske Job Satisfaction Scale (Koeske, Kirk, Koeske & Rauktis, 1994).

Procedures Used and Results Obtained

The data was analyzed using multiple regression because more than one predictor was included in the hypotheses. As well, the six measures were rather highly correlated, so multicolinarity can be a problem. A multiple regression was helpful in order to determine the relative contributions of the six measures of conflict resolution to Job Satisfaction. When this regression was carried out, Job Satisfaction was found best predicted by the use of an Integrating Style with Coworkers (INCOST) for handling disagreements in discharge planning; $F(1, 318) = 20.23$, $p = .01$, Bonferroni adjustment made. The other measures of Integrating and Compromising Styles of handling conflict with coworkers, clients and client's families were not found to be significant predictors of Job Satisfaction.

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Discussion

When confronted with disagreements in discharge planning which involved other professional staff, this study found that use of an Integrating Style positively contributed to social workers' Job Satisfaction. Social workers who used an Integrating Style with other professional staff encouraged an exchange of information and examination of differences. Through these problem solving efforts, creative solutions acceptable to both parties were more likely to have occurred (Rahim, 1983).

In those cases where disagreements in discharge planning occurred, social workers in this study reported that the patient, family and hospital staff were all frequently involved. When all these parties were involved in discharge planning conflicts, the most frequent were among the patient, family and/ or hospital staff regarding the length of stay (77%). This was followed by conflict among the patient, family and/or hospital regarding the type and availability of services for post- hospital care (72%) and conflict between the patient, family and/or hospital staff regarding the post-hospital destination of the patient (67%).

These findings are similar to prior studies which also found that disagreements about discharge planning most often involved the hospital staff and the patients' family (Donnelly & King, 1990; Abramson, Donnelly, King & Mailick , 1993). Another study also found some of the most frequent disagreements in discharge planning were about the post - hospital destination of the patient, the type and availability of services for aftercare and the patients' readiness for discharge (Donnelly & Siegel, 1993).

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Of interest, is that use of an Integrating Style of handling disagreements in discharge planning with clients and/or their families, was not significantly related to Job Satisfaction. Explanations for why an Integrative Style of Handling Conflict with other professional staff was the only significant relationship predicting Job Satisfaction may be suggested by prior research.

One study examined job satisfaction in psychiatric social workers and found that the most consistent predictor of overall job satisfaction was professional respect from other disciplines. This finding emphasized the importance of the interpersonal sources of job satisfaction in multidisciplinary hospital settings (Marriot, Sexton & Staley, 1994). Another study which looked at occupational tedium in social service professionals, found tedium to be negatively linked with work satisfaction and positively linked with the desire to leave the job. Lower levels of tedium were reported in social workers who received positive social feedback from other colleagues and supervisors. This suggested that social workers may be particularly sensitive to people as sources of both emotional stress and support. (Pines & Kafry, 1978). Finally, research on job satisfaction among social work discharge planners found that lack of cooperation from other hospital staff (especially physicians) with discharge planning rated third as a source of job dissatisfaction for both M.S.W. and non M.S.W. working in acute care hospitals. This too underscored the importance of respect and cooperation from other professional staff in determining hospital social workers overall satisfaction with their jobs (Kadushin & Kulys, 1995).

The findings of my study and research discussed above, suggest that a major component of job satisfaction for social workers in host settings is the quality of

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relationships with other professional staff. An Integrating Style for handling conflict involves both parties having a high concern for satisfying the concerns of other. Social workers who develop creative solutions to conflicts acceptable to both parties can greatly enhance interdisciplinary collaboration. In a host setting, these interdisciplinary relationships take on major importance; like any group in the minority, social workers in host agencies are vulnerable and under scrutiny (Dane & Simon, 1991). There also may be tendencies for hospital social workers to derive job satisfaction based upon how they collaborate with other medical staff, especially physicians. These tendencies may arise from a strong medical social work tradition that has acknowledged the superior status of physicians as a condition of social work survival in medical organizations (Kerson, 1981; Roberts, 1989).

It has been suggested that social work supervisors need to address these issues by focusing on developing a stronger sense of practice excellence. It is hoped this may assist social workers to keep subjectively clear their actual level of satisfaction with the work itself versus being highly dependant on the quality of team interactions to derive variety, autonomy and value in their work (Marriot, Sexton & Staley, 1994).

Comments from social workers in this study alluded to the powerful impact of interdisciplinary team interactions on their degree of job satisfaction. The following quotes illustrate how the positive or negative nature of these interactions influenced social workers' attitudes about their job.

One social worker wrote: " I work in a federal, teaching hospital. The most frequent conflicts in discharge planning are with the house staff - interns, residents. Some

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of them have the most appalling attitudes towards our patients referring to them as dirtbags, gomers and bogus admissions. They want them discharged without what seems like adequate care and assessment. However, I work in a speciality area in which I have formed excellent and satisfying relationships with the attending and fellow physicians. If I have a conflict with the resident, I deal with the attendings and fellows and can use that relationship to the benefit of the patient. Conflicts are then normally resolved such that I do not feel the patient is placed at risk."

Another social worker stated, "The most frustrating element of my job is the egotistical, arrogant attitudes of some (not all) doctors especially regarding their willingness to recognize when enough is enough; that the patients' age or condition do not warrant heroic measures, that hospice may be worth considering and discussing with the family. Doctors often kick the wrong dog, assuming that because they went to medical school they alone have solutions and are the sole font of wisdom."

Other social workers reflected upon how support from other professionals, evidenced by mutual problem solving and respect, was a major factor contributing to positive feelings about their job. One wrote, " I felt more job dissatisfaction and powerlessness when I was part of my hospital's social work department. In August of 1995 I moved into a newly created multidisciplinary department and am now known as a patient care resource manager; jointly paid by the hospital and the physician group with whom I work. My job satisfaction has improved immensely because I have more autonomy, creativity is encouraged and I feel more belonging to the medical team."

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Finally, another social worker commented, " The positive of where I work (a VA hospital), and a strong positive at that, is that discharge planning is an interdisciplinary process. The decision as to when the patient is ready to discharge is made by the entire team. It is good that discharge is a team effort because many families are under the impression that when the veteran comes to the VA Nursing Home Care Unit that the placement is permanent. Many families do not want to discuss discharge options. And many families get Congressional involvement. Some veterans then remain in the VA for political reasons."

This study also found that a Compromising Style was not found to be a significant predictor of Job Satisfaction in any conflict situation whether or not this involved other professional staff, clients or clients' families. A Compromising Style requires that both parties give up something in order to make a mutually acceptable decision, split the difference, exchange concessions or seek a middle ground position. (Rahim, 1983). Perhaps this Style did not impact positively on Job Satisfaction because solutions of this nature imply that each party has only a moderate interest in satisfying the others' concerns; this implies less opportunity for positive interdisciplinary collaboration and recognition.

In contrast, an Integrating Style is characterized by both parties having a high degree of interest in satisfying the others' concerns. Finding creative solutions acceptable to both parties provides the opportunity for positive interdisciplinary collaboration and recognition. In the process, social workers may use their valued skills, abilities and have new learning experiences. These are all work attributes that have been found to positively

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contribute to Job Satisfaction (Locke, 1976; Marriot, Sexton & Staley, 1994; Jayarante & Chess, 1984).

The current health care environment is such that the potential for disagreements in discharge planning are anticipated to increase from pressures related to shorter lengths of stay, fewer options for aftercare (Fein, 1995), heavier caseloads with more complex and demanding cases (Siefert, Jayaratne & Chess, 1991), increased competition between social work and nursing for the primary role as discharge planner (Ingelhart, 1990; Freeman, 1992, Cowles and Lefcowitz, 1992; Kulys & Davis, 1987; Egan & Kadushin, 1995), managed care and frequent reorganizing and downsizing of many hospitals (Globerman, Davies & Walsh, 1996; Berger, Cayner, Jensen, Mizrahi, Scesny & Trachtenberg, 1996; Ross, 1993; Cornelius, 1994; Cowles & Lefcowitz, 1992; Dane & Simon, 1991).

The current pressures discussed above, suggest that discharge planning conflicts will continue to be a chronic feature of the health care landscape. Given this, it is important for the social work profession to understand which behavioral styles of conflict resolution may contribute to job satisfaction for health care social workers. Although conflict is often viewed as an activity which is almost totally negative and possessing no redeeming qualities, conflict may also be viewed as essential to all change, growth, learning, awareness, relationships and work. The difficulty is not with conflict, but how we respond to it. (Cloke, 1994; Hocker & Wilmont, 1995).

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Implications for future research

This study and prior research (Marriot, Sexton& Staley, 1994; Kadushin& Kulys, 1995; Pines & Kafry, 1978) suggest that physicians, traditionally at the apex of the health care delivery system, have a strong influence on social worker's level of job satisfaction in health care settings. However, in the present health care climate managed care has become a powerful influence and somewhat lessened physician dominance over the allocation of health care resources and control over other members of the health care team.

Given this, social workers now engage in frequent and extensive collaborations with managed care/insurance companies over crucial issues related to discharge planning. Therefore, it would also be important to explore what styles of handling conflict are used by social workers during discharge planning conflicts involving managed care/insurance case managers and the relationship to the degree of job satisfaction reported by these social workers.

This study did not obtain information regarding the role and discipline of the other professional staff (e.g attending physician, head nurse, staff physical therapist, etc) engaged in the discharge planning conflicts. It would be useful to further understand whether the role and discipline of other health care professionals had a relationship to styles of handling conflict used by social workers in discharge planning conflicts. As well, it would valuable to include variables such as gender and ethnicity to gain further insight into how these may influence how conflicts are handled.

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Research Question 4

Research Question 4 concerns personal and occupational stressors and stress modifiers in relation to Job Satisfaction and Burnout.

Research Question 4:

Occupational and personal stressors will effect the outcomes Job Satisfaction and Burnout, modified by coping resources: Training in mediating conflicts which may arise in discharge planning; Integrating (INSUM) and Compromising (COSUM) Styles of handling conflict; Social Support (SOST).

Measures of occupational stressors are the reporting of Role Overload (ROVL) and Role Boundaries (RBST). The personal stressor is Disturbing Life Events (this was CH 150 in the questionnaire). Stress modifiers are Integrating and Compromising Styles of handling conflict, Job Satisfaction and Burnout (as previously defined) and Training in mediating conflicts (this was CH 9 in the questionnaire).

Measures used

Occupational stressors were measured by two scales of the Occupational Stress Inventory; Role Overload and Role Boundary (see section on the instrument).

Role Overload (ROVL) is defined as the extent to which job demands exceed resources (personal and workplace), and the extent to which an individual is able to accomplish expected work loads. This measure is a ten item scale with items which included: "I am expected to perform tasks on my job for which I have never been trained" and "I work under tight deadlines" (Osipow & Spokane, 1981).

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A high score means increased reporting of overloading events such as their work load increasing. The mean response for the prorated scores in this study was 3.07 (cue: 1 rarely; 3 often; 5 most of the time).The Alpha reliability for the prorated scores in this study is .82.

Role Boundary (RBST) is defined as the extent to which the individual is experiencing conflicting role demands and loyalties in the workplace. This is also a ten item scale with items such as: '' My supervisor asks for one thing but really wants another" and " I feel caught between factions at work" (Osipow & Spokane, 1981).

A high score indicates concern about role boundaries and increased reporting of events such as feeling unclear about lines of authority or caught between conflicting supervisory demands and factions. The mean response for the prorated scores in this study was 2.44 (cue: 1 rarely; 3 often; 5 most of the time).The Alpha reliability for the prorated scores in this study is .61.

Personal stressors were measured by a dichotomized variable (CH 150) . Social workers were asked to respond yes or no regarding whether or not there had been any events (e.g. personal relationship problems, divorce, move) in their life during the past one year which had been disturbing; 51% reported having experienced Disturbing Life Events over the past year. They were also given the opportunity to list the three most disturbing events in order to provide qualitative data on their experiences.

Training in mediating conflicts which may arise in discharge planning, a stress modifier, was measured by a dichotomous variable (CH 9). Social workers were asked to respond yes or no regarding whether or not they ever received any in-service and/or

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additional training over the past year in mediating conflicts which may arise in discharge planning.

Social support, another stress modifier, was measured by the nine item Social Support (SOST) scale of the Occupational Stress Inventory. Social Support is defined as the extent to which the individual feels support and help from those around him/her. Sample items are: " There is at least one important person to me who values me" and "I feel loved" (Osipow & Spokane, 1981).

A high score indicates a lot of social support. The mean response for the prorated scores in this study was 4.37 (cue: 1 rarely; 3 often; 5 most of the time).The Alpha reliability for the prorated scores in this study was .91.

Integrating and Compromising Styles of handling conflict, Job Satisfaction and Burnout were all measured as was previously described in prior hypotheses.

Procedures used and results obtained

This hypothesis was tested using multiple regressions because more than one predictor was included. As well, this was helpful towards understanding the relative contributions of each variable. Although many of the correlations in Table 9 are probably statistically significant, only those relevant to this hypothesis will be discussed below.

An examination of the intercorrelations of the measures needed to test this hypothesis (see Table 9) disclose the following:

14. The outcomes of Job Satisfaction (JSAT) and Burnout (BUST) are intercorrelated; $r = -.53$, ($p < .05$).

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2. Personal stressor, Disturbing Life Events, is correlated -.13 with Job Satisfaction and .21 with Burnout, ($p < .05$).

3. The occupational stressor, Role Overload (ROVL) is correlated moderately with Job Satisfaction (r = - .29) and Burnout (r = .38) but only slightly with the personal stressor, Disturbing Life Events (r = -.13) ($p < .05$).

4. The outcomes of Job Satisfaction (JSAT) and Role Boundary (RBST) are intercorrelated; r = -.70 ($p < .05$).

5. Stress modifiers (Training- CH 9, Social Support) have low correlations with outcomes (Job Satisfaction and Burnout) and with stressors (Role Overload, Role Boundary , Disturbing Life Events - CH 150)($p < .05$).

Based on the observations presented above, the hypothesis would seem to be reduced to a statement about the relation of stressors to outcomes. Regressing JSAT on ROVL and RBST yields:

Rsq = .48, R=.69; the beta for RBST is -.70

the beta for ROVL is -.03

$$Z\,(JSAT) = -.70 \quad Z\,(RBST) + .03\,Z\,(ROVL)$$

Finally, regressing BUST on ROVL and RBST yields:

Rsq = .29, R = .54, the beta for RBST is .43

the beta for ROVL is .22

$$Z\,(BUST) = .42\,Z\,(RBST) + .22\,Z\,(ROVL)$$

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Table 9 : **Intercorrelations of Job Satisfaction (JSAT), Burnout (BUST), Role Overload (ROVL), Role Boundary (RBST), Social Support (SOST), Integrating Style of Handing Conflict (INCOST, INFAST, INCLST), Compromising Style of Handling Conflict (COCOST, COFAST,COCLST), Training (CH 9) and Disturbing Life Events (CH 150)**

Correlation:

	JSAT	BUST	ROVL	RBST	SOST	INCOST	INFAST
JSAT	1.000	-.533	-.293	-.688	.216	-.245	-.155
BUST	-.533	1.000	.379	.512	-.270	.190	.219
ROVL	-.293	.379	1.000	.455	-.104	-.070	-.097
RBST	-.688	.512	.455	1.000	-.183	.192	.139
SOST	.216	-.270	-.104	-.183	1.000	-.151	-.109
INCOST	-.245	.190	-.070	.192	-.151	1.000	.611
INFAST	-.155	.219	-.097	.139	-.109	.611	1.000
INCLST	-.113	.179	-.083	.095	-.129	.583	.798
COCOST	-.098	.123	-.124	.073	-.072	.609	.495
COFAST	-.086	.123	-.132	.028	-.057	.426	.519
COCLST	-.007	.029	-.155	-.026	-.027	.498	.620
CH9	.149	-.145	.005	-.049	.225	-.103	-.013
CH150	-.131	.212	.161	.136	-.110	-.010	-.024
THRD	-.110	.097	.159	.076	-.027	.039	.073

(In the JSAT and BUST columns, the CH9, CH150 and THRD values are marked by hand with ovals and strike-throughs.)

Table 10 : **Values of Intercorrelations for Job Satisfaction (JSAT), Burnout (BUST) Role Overload (ROVL) and Role Boundary (RBST)**

r	JSAT	BUST	ROVL	RBST
JSAT	1.00	-.53	-.29	-.69
BUST	---	1.00	.38	.51
ROVL	---	---	1.00	.46
RBST	---	---	---	1.00

The above regressions show that the hypothesis regarding the effects of occupational and personal stressors on Job Satisfaction and Burnout, cannot be fully tested. The correlations between the occupational stressor Role Overload and stress modifiers (Training and Social Support) and the outcomes (Job Satisfaction and Burnout)

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are insufficient to support this investigation. However, the betas for Role Boundary (-.70 and .43) do indicate significant relationships with the outcomes of Job Satisfaction and Burnout.

Discussion

In this study, the occupational stressor Role Overload , personal stressors (Disturbing Life Events) and stress modifiers (Social Support, in service Training, Styles of Handling Conflict) were not found to have significant effects on outcomes (Job Satisfaction and Burnout) or significant effects on outcomes thorough stress modifiers.

However, the findings do show that social workers who are more concerned with Role Boundary issues report lower Job Satisfaction and higher levels of Burnout. This is revealed by reducing the effects of Role Boundary (RBST) whereby it is seen that Role Overload (ROVL) has little effect on the outcomes; Job Satisfaction (JSAT) and Burnout (BUST). Therefore, these findings suggest that concerns about Role Boundary, rather than Role Overload, are strong determinants of hospital social workers' level of Job Satisfaction.

Social workers who are concerned about Role Boundary issues experience conflicting role demands and loyalties in their hospital setting. They feel caught between conflicting supervisory demands and factions. They may report not feeling proud of what they do or having a stake in the enterprise. They may also report being unclear about authority lines and having more than one person telling them what to do (Osipow & Spokane, 1981).

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The frequency of Role Boundary concerns for this sample of social workers (see Table 11), revealed a large percentage who often or most of the time felt they were overqualified for their job (43%). Given that the majority of respondents (58%) spent more than half to all of their time providing discharge planning (see Table 3), this may reflect the trend for social work referrals to be primarily focused on concrete services due to time constraints imposed by shortened lengths of stay. It has been suggested by prior social worker research that concrete resource provision is often the primary focus of the discharge planning role (Kadushin & Kulys, 1993).

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Table 11: Role Boundary Issues: Social Workers' Responses by Percentage (N=355)

	Rarely True	Often True	True Most of the Time
I feel overqualified for my job	57%	32%	11%
My supervisor provides me with useful feedback about my performance	47%	36%	17%
My supervisor asks for one thing but really wants another	86%	12%	2%
I have a clear understanding of how my supervisor wants me to spend my time	20%	42%	38%
I feel conflict between what my employer expects me to do and what I think is right and proper	65%	30%	5%
I feel caught between factions at work	60%	35%	5%
My supervisors have conflicting ideas about what I should be doing at work	84%	12%	4%
Its clear who really runs things where I work	28%	46%	26%
I have divided loyalties on my job	58%	35%	7%
I spend time concerned with the problems others at work bring to me	46%	48%	6%

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I worry about whether the people who work for/with me will get things done	69%	27%	4%
People who work for/ with me are really hard to deal with	84%	13%	3%

Historically, the social work profession has been ambivalent about primarily performing concrete service provision. Medical social workers have expected their role to have more to do with counseling, psychotherapy or emotional and behavioral problems than other health professional groups expect of this role (Cowles & Lefcowitz, 1992; Cowles & Lefcowitz, 1993; Ross, 1993; Kadushin & Kulys, 1993).

It is suggested that other Role Boundary issues frequently reported by social workers in this study may also reflect the difficulties of working in a host setting during a period of change and fiscal constraints. Often or most of the time, many social workers felt: conflicted about what their employer expected them to do and what they felt was right and proper (35%); caught between factions at work (40%) and divided loyalties at the job (42%).

These Role Boundary conflicts were described by this social worker who wrote, "Due to the financial problems of hospitals and the control of managed care insurance companies, staff in all professions are being cut. This leaves the social workers to constantly try to balance out hospital pressures and needs of children and their families. I am forced to give crisis intervention most of the time. I consider it a luxury when I can give a family some semblance of time and problem solving, parent education, etc. Social work schools need to teach the reality of the job."

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The negative impact of Role Boundary issues on Job Satisfaction reported in this study, is consistent with prior research on social workers and other professionals (Harrison, 1980; Siefert, Jayaratne & Chess, 1991; Kahn, Wolfe & Sneok, 1964; Locke, E., 1976; Kadushin & Kulys, 1995 Dane & Simon, 1991). The impact of Role Boundary issues was also described by Donnelly (1992) who wrote:

> Hospital social workers play to a number of audiences simultaneously: patients and their families, hospital administrators and non professional staff and other professionals in the treatment team. The consequences of neglecting this role defining task can be dramatic for the individual worker both in terms of burnout, declining morale and loss of influence and access to resources in a climate of fiscal constraint. (p 107).

This quote highlights how hospitals, host institutions to social workers, give rise to conditions perpetuating Role Boundary concerns. Host settings are, by definition, organizations whose mission and decision making are defined and dominated by people who are not social workers (Dane & Simon, 1991). Role strain and ambiguity arise in hospitals because many professionals are concerned with similar activities and interventions related to the client's welfare. In health care settings, social workers are not always perceived as the only professionals qualified to perform social service tasks and discharge planning (Cowles & Lefcowitz, 1992, 1995; Dane & Simon, 1991; Kulys & Davis, 1987; Eagan & Kadushin, 1995).

Hospital social workers may perceive themselves as the most qualified professional to provide the assessment, counseling and coordination inherent in the discharge planning

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process. However, other disciplines may not share this point of view. Several studies report that physicians and nurses expect social workers to arrange for the concrete service portion of the discharge planning process but do not expect social workers to perform psycho social tasks. Nurses are reported to view themselves as qualified to assess and intervene in the social and emotional problems of patients and families or to view these tasks as areas for collaboration (Cowles & Lefcowitz, 1992; Lister, 1980; Kulys & Davis, 1987; Egan & Kadushin, 1995; Ingelhart, 1990).

The social work literature contains efforts to understand how this lack of role definition has occurred. A common theme to emerge is that the role of the medical social worker has never been clearly defined. Since at least the mid -1950s, the literature has reported medical social workers feeling that their role in direct service is misunderstood by other health care professionals, especially physicians. Patterns observed in these studies suggest that role ambiguity and strain may arise from the social work position that its distinguishing focus is the person-in-environment. This focus means that social workers expect their direct service role to be fairly equally directed to both the emotional and social-environmental problems of both the primary client and his/her family.

Other professional groups, however, may not be attuned to this position of the social work profession. Rather, there may be a narrower focus of the social - environmental problems of people and on connecting them with concrete services and community resources(Lister, 1980; Cowles & Lefcowitz, 1992; Dane & Simon, 1991). Current pressures from prospective payment systems to control health care costs by reducing hospital stays also serves to increase these already existing tendencies for social

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work referrals to be restricted to discharge planning and associated resource-linkage activities, to the neglect of the psycho social component of discharge planning and other aspects of health problems (Cowles & Lefcowitz, 1995).

Many comments written by social workers coupled with reports of Disturbing Life Events involving changes in the health care environment, reflect the toll Role Boundary issues have taken on their level of job satisfaction. Three major themes emerged; increasing competition between and role blurring of nurses and social workers regarding discharge planning responsibilities, the impact of managed care and hospital downsizing.

Concerns about role blurring and increasing competition between nurses and social workers for the role of discharge planner were reported in comments such as the following. One social worker wrote, " The conflicts I have felt have not been with families/clients but with our role as social workers—discharge planning being taken over by RNs. They are not trained to assess psycho-social needs, they have difficulty in viewing a patient holistically, their orientation is strictly medical. This orientation presents many problems."

Another commented, "There is a lot of fear in the hospital setting that nurses or case managers are trying to take the discharge planning role away from the social worker. It is well known that we have too much to do, with little time or resources to do it adequately. Nurses think they can do it all, usually without a bachelor's degree or training in psycho social assessments. I feel social workers are put in a no win situation. They are making our positions unrealistic and plan to down grade it to a "technical" position; concrete services only." Similar sentiments were shared by this social worker, "It is

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increasingly hard to work with RN staff, especially clinical specialists. Their roles are changing and often it is in conflict with social work roles and areas of expertise."

Finally, a social work supervisor reported," My hospital, like others, uses RN discharge planners who also do Utilization Review and case management. This change came about 4 years ago; prior to that, social workers did all the discharge planning. If I have conflicts, it is with the discharge planners who see themselves as quasi - social workers and counselors. The role boundaries at my hospital are blurred."

The impact of managed care on social workers was reflected in comments which included the following. One social worker wrote," Current big problem is ambiguity about fulfilling both discharge role and mental health role—ambiguity from administration, social work leaders and insurance companies."

A social work supervisor observed, "It seems the most frustrating conflicts are with the managed care reps. This is due in part to poor role definition (who does what on what cases), poor communication and unrealistic expectations (e.g. request a 3:30 PM Friday nursing home placement). In light of the fact that my hospital is involved in a shared-risk contract with one HMO for it's Medicare population, this makes things even more complicated. Sometimes, staff complain that we have to jump to each request by this HMO neglecting other patients. On the other hand, if we are not efficient with this population, our hospital loses money. There is also conflict with a nursing group, called case managers, within the hospital. This conflict is due, again, to murky role definition and competition for who is responsible for discharge planning. "

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The pressures of cost containment were also felt by this social worker,"One of the most difficult dilemmas at our acute care hospital is the push to move people out of the hospital as quickly as possible to save the hospital money. Saving money appears more important than patient's psycho social needs. We rarely see patients for counseling."

Finally, one social worker expressed how the burden of Role Boundary concerns, partly attributed to the impact of managed care, had influenced her career plans. She wrote; "I feel that social work is very undervalued. We advocate more for our clients than we do for ourselves. I also feel grad school is going to have to start addressing managed care issues and how to deal with the ethics involved. I am currently training for a new career - gemology! After dealing with people's frustrations and anger it is refreshing to deal with the precision and non-changing environment of gemstones!"

The financial pressures many hospitals are experiencing, often causing downsizing, were also reflected in both additional comments and reports of Disturbing Life Events. One social worker related," I worked at the same hospital for 17 years, taking early retirement in June. I was manager of that Department for 16 years but carried a caseload throughout that time. Then, due to downsizing, I was demoted when social work was merged with Utilization Review. For a short time I was Assistant Director of combined departments, then was demoted again." Another social worker wrote, "My role is changing as my unit is closing only to be absorbed by other units in the hospital. For now, I wish people would concentrate on being more consumer oriented when they become involved in HMOs and managed care contracts." Finally, other social workers mentioned

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hospital downsizing as a Disturbing Life Event which negatively influenced their behavior on the job.

The preceding information suggests how Role Boundary issues may have a negative impact upon hospital social worker's level of Job Satisfaction. It is suggested that the current health care climate - which is rapidly changing due to managed care, hospital downsizing and increasing competition from nurses for the discharge planning role—may contribute to social workers' Role Boundary concerns. These findings also imply that Role Boundary dilemmas wrought by current changes in health care, are superimposed upon preexisting role and value conflicts experienced by social workers who practice in a host setting (Dane & Simon, 1991; Kulys & Davis, 1987; Eagan & Kadushin, 1995; Cowles & Lefcowitz, 1992,1995).

Implications for future research

Overall, these findings imply that ongoing research is needed to monitor how current changes in health care—particularly managed care, downsizing and the changing role of nurses—affect hospital social workers' level of Job Satisfaction and Burnout.

As well, prior social work research has explored interdisciplinary expectations of the medical social worker in the hospital setting (Cowles & Lefcowitz, 1992; Cowles & Lefcowitz, 1995; Kulys & Davis, 1987). However, there are no studies which explore expectations of social workers, managed care case managers and/or insurance companies regarding expectations of the respective roles each should play in discharge planning. This would seem an important area for future research as managed care is an ever growing

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presence in health care. It is estimated that by the year 2000, 90 percent of all medical benefits administration will be handled by managed care organizations (Berkman, 1996).

Further research is also needed on what type of training would help social workers cope with the many conflicts and strains inherent in providing discharge planning services during a period of transition and change in the health care industry. This study did not find that Training in mediating conflicts which may arise in discharge planning modified the effects of Occupational and Personal stressors on Job Satisfaction and Burnout. However, further information is needed on how social workers obtained this training and what it entailed.

Finally, comments from some social workers in this study implied their training in social work school did not fully prepared them for the current challenges facing hospital social workers in the changing health care environment. Therefore, it is also suggested that future research continue to assess curriculum development and continuing education needs relevant to social workers currently practicing in rapidly changing health care settings.

Research Question 5

Research Question 5 is concerned with relationships between in service and/or additional Training in mediating discharge planning conflicts received over the past year, Role Overload and Job Satisfaction.

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Research Question 5

Among the subsample reporting no Training in mediating discharge planning conflicts (controlling for exogenous factors) there will be a negative relationship between Role Overload (ROVL) and Job Satisfaction (JSAT). This relationship will not be observed among the sample reporting they did receive Training in mediating discharge planning conflicts (CH 9).

Measures used

Training in mediating discharge planning conflicts was measured by a screening question (CH 9) which asked respondents to answer "yes" or "no" about ever receiving any in-service and/or additional training in the past year to help them mediate conflicts which arise in discharge planning. Those who answered "yes" were asked (CH 10): in the past one year, about how many hours of training did you receive about mediating conflicts? Of those social workers With Training (n = 147) , only 80 reported the number of hours of received in the past one year (the average number of hours was 3). The larger group of social workers, those Without Training (n = 206) were used to specify the hypothesized direction of the relationships between Training, Role Overload and Job Satisfaction.

The exogenous variables controlled for were: sex; marital status; age; ethnicity; primary area of work; nature of primary position; hours per week at primary area of work; marital status; disturbing life events over the past year; type of hospital where employed; auspice of hospital.

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Role Overload (ROVL) and Job Satisfaction (JSAT) were all measured as was described in prior hypotheses.

Procedures used and results obtained

This hypothesis was tested using correlational analyses. Results of testing this hypothesis are as follows:

(1) When Training in mediating discharge planning conflicts is measured by CH 9, the 206 social work respondents answering "no" had scores on ROVL and JSAT which were correlated $r = . - 26$ ($p < .05$). This means that social workers Without Training and more frequent incidences of Role Overload, also report lower levels of Job Satisfaction .

(2) The 147 social work respondents With Training to mediate conflicts in discharge planning in the past year, had scores on ROVL and JSAT which were correlated $r = -.33$ ($p < .05$). This means that social workers With Training and frequent incidences of Role Overload, will report even lower levels of Job Satisfaction than the group who report no Training and frequent incidences of Role Overload.

These correlations do not differ significantly from each other; each is significantly differently from 0 (no relation), Bonferroni adjustment made. As well, these results confirm the first part of the research hypothesis; among the subsample of social workers reporting no Training in mediating discharge planning conflicts, there will be a negative relationship between Role Overload and Job Satisfaction. However, the results do not confirm the second part of the research hypothesis; that this relationship will not be observed among those who report having Training in mediating discharge planning

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conflicts. In order to further understand these findings, an examination of the means of these two groups is useful (Table 12).

Table 12: Mean Scores For Comparing Role Overload and Job Satisfaction Of Social Workers With and Without Training in Mediating Discharge

	Role Overload		**Planning Conflicts Job Satisfaction**	
Report Of Training	**Mean**	**SD**	**Mean**	**SD**
With Training (n = 147)	3.07	.77	7.86	1.67
Without Training (n = 206)	3.11	.79	7.26	1.75

Referring to Table 12, the average response to Role Overload (9 items) corresponds to 3.07 (where the range of 2.5 - 3.5 indicates Often True) for those With Training and 3.11 for those Without Training. There is obviously very little difference between the average responses of each group.

Regarding Job Satisfaction, the score is the sum of code values for 18 items (where the range is from 1 "very satisfied" to 11 "very dissatisfied"). The mean of those with Training falls at 7.86 while the mean for those without Training is 7.26.

Considering these sample sizes, these means differ at a level corresponding to a t - ratio of 5.18 ($p = .05$, Bonferroni adjusted). Thus, it is found that reports of incidences of Role Overload are effected by having had Training in mediating discharge planning conflicts.

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Discussion

This study has found that social workers Without Training over the past year in mediating discharge planning conflicts (n = 206), have the potential for Role Overload issues to negatively effect their level of Job Satisfaction. For the group With Training in mediating discharge planning conflicts (n = 147) who also report incidences of Role Overload, their level of Job Satisfaction was even lower than the group Without Training.

Role Overload has been implicated in contributing to burnout and lower levels of job satisfaction in human service professionals because of frustrations which include case overload with no structured "time outs," lack of training specific to the job, inadequate leadership and extensive administrative and paperwork tasks (Siefert, Jayarante & Chess, 1991; Ratliff, 1988; Cherniss, 1980). Social workers experiencing Role Overload may describe their work load as increasing, unreasonable and unsupported by needed resources. They may describe themselves as not feeling well trained or competent for the job at hand, needing more help and working under tight deadlines (Osipow & Spokane, 1981).

Cherniss (1980) postulates that job stress occurs when there is a perceived imbalance between demands and resources. This stress increases when the demands escalate or the resources for meeting these demands dwindle. Such a gap between resources and demand will create much stress and strain for the worker creating potential for burnout and low levels of job satisfaction.

Cherniss' theory provides a framework to help explain why social workers

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Without Training in mediating discharge planning conflicts have increased potential for Role Overload to negatively effect Job Satisfaction. Social workers Without Training may feel unable to meet the demands of discharge planning conflicts because they lack resources (e.g. special skills such as mediation) to meet the demands of the situation. Lack of special training may coexist with other factors such as dwindling resources for meeting the demands of discharge planning (e.g. shortened lengths of stay and fewer options for aftercare). These factors cause stress and strain to further escalate and create even more potential for burnout and lower levels of job satisfaction. One social worker stated it this way, "In the context of short term discharge planning, special skills are required for mediating disagreements. More training in short term conflict resolution would be helpful, particularly in the present atmosphere of health care where social work values are competing with the needs of the hospital to contain costs and shorten lengths of stay."

Prior research has also confirmed that workers whose training enables them to meet the demands of a job by using their special skills and expertise report higher levels of overall job satisfaction (Marriott, Sexton & Staley, 1994; Locke, 1976; Siefert, Jayaratne & Chess, 1991; Kadushin and Kulys, 1995). This further suggests that social workers Without Training in mediating discharge planning conflicts have the potential for Role Overload issues to negatively effect their level of Job Satisfaction because they may not feel completely trained to handle these conflicts.

The conflictual aspects of discharge planning strongly suggest the need for special skills and expertise in order to effectively intervene. Social work researchers

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have identified the frequent occurrence of disagreements in discharge planning which are caused by a variety of contributing factors including shortened lengths of stay, fewer options for aftercare and the patient and families' emotional reactions to illness and disability. These social, economic and familial repercussions all converge to create a highly charged arena for discharge planning (Abramson, 1985; Abramson, 1988; Abramson, 1990; Abramson, Donnelly, King & Mailick, 1993; Donnelly & Siegel, 1993; Donnelly, 1992).

More challenging to understand, is the finding that social workers With Training and incidences of Role Overload had levels of Job Satisfaction lower than the group Without Training. One explanation may be that Training was sought out by this group because they were experiencing Role Overload and/or low levels of Job Satisfaction. Perhaps the training received still did not give them the resources needed to meet the demands wrought by their job; this frustration may have further eroded their levels of Job Satisfaction.

As was discussed earlier, there are many factors contributing to discharge planning conflicts. Even a social worker with extensive training in mediation would not be able to control the larger forces in health care which are the catalyst for many of these disputes; managed care, prospective payment systems, shortened lengths of stay, fewer options for post - hospital care (Abramson, 1985, 1988, 1990; Abramson, Donnelly, King & Mailick. 1993; Donnelly & Siegel, 1993). Training in mediating discharge planning conflicts might have paradoxically increased the frustration of these social workers by giving then unrealistic expectations of the impact they could have in these conflict

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situations. Social workers With Training may have found, despite investing time and energy, that training received did not make a difference in the frequency of Role Overload or on their level of Job Satisfaction. Despite their best efforts, the larger forces in health care remained out of their control and they still had to deal with the sequella; e.g. angry families, pressure for quick discharges, not enough staff or options for aftercare. This would suggest that health care social workers also need to be well trained in macro level interventions such as community organizing and political action.

As the following comments suggest these explanations may have credence, although further research is certainly needed to fully understand this finding.

The impact of shortened lengths of stay are reflected in these comments. One social worker observed, " More social workers are needed more than training in mediating discharge planning conflicts. As well, time is the key to doing a proper job."

Another lamented, " The creativity I used to know in hospital social work is gone. There isn't time. There isn't really enough time to really talk to the patients anymore. And they are in for such a short time. Our families react with anger at the short stays and are often unrealistic in their expectations - often because the doctor was not clear, often because they do not want to hear what the doctor says. I have to work so fast that it is hard to keep a client focus. My coworkers are pressing me for a discharge plan, the doctors are screaming at me and then the families are getting angry! Not a pretty picture. I used to love being a hospital social worker; loved the patient contact and was proud of my abilities and creativity. My satisfaction has been cut in half - deeply eroded is a better way to put it."

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Another social worker commented, "One concern is how discharge planning is defined. If that includes a bio - psychosocial assessment and helping the patient and/or family deal with the emotional and practical issues related to diagnosis and prognosis, then we have a viable definition with which I - as a clinical social worker - can agree. Unfortunately, the emphasis is becoming more on time and money, leaving little opportunity for appropriate assessment and treatment. It is here that the potential for conflicts is highest and ethical issues will arise."

Other social workers specifically mentioned areas for additional training which would help them better meet the demands of their role as discharge planner.

One commented, "It is hard on me to deal with angry families—depersonalizing the anger is not easy. I have attended seminars on helping older patients/families deal with anger and grief. This was helpful." From another, "Graduate social work school actually did little to prepare us for the real job world, especially in the area of conflict management. Further education is also needed in the area of empowerment." Another social worker commented, "Conflict resolution training would be helpful as well as assertiveness training. " This sentiment was echoed by another social worker who wrote, "I am sure that some training in mediating disagreements in discharge planning would help, however, I think that social workers also need to be trained to be more assertive. This would help social workers advocate for their contribution to health care. This is increasingly important as hospital staffs shrink and it often seems that the skills of social workers and the values of our profession are not considered very important."

Finally it is interesting to see the entire samples' responses to Role Overload

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items (see Table 13). Clearly, many social workers had frequent occurrences. In fact, the responses below suggest that some aspects of Role Overload may be normative for social workers in the current health care climate.

Table 13: Role Overload: Social Workers' Responses By Percentage (N=355)

	Rarely True	Often True	True Most of the Time
My job requires me to work in several equally important areas at once	9%	48%	43%
I am expected to do more work than is reasonable	27%	48%	25%
I have to perform tasks that are beneath my ability	53%	42%	5%
At work I am expected to do too many different tasks in too little time	36%	47%	17%
I feel my job responsibilities are increasing	14%	47%	39%
I am expected to perform tasks on my job for which I have never been trained	66%	26%	5%
I have to take work home with me	66%	26%	8%
I work under tight time deadlines	24%	47%	29%
I wish that I had more help to deal with the demands placed upon me at work	36%	46%	18%

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Most striking was that often or most of the time: 86% reported their job responsibilities were increasing and they were working under tight time deadlines; 73% felt they were expected to do more work than was reasonable; 64% reported having to do too many tasks in too little time and wished they had more help to deal with the demands placed upon them at work.

The preceding suggests that Training to mediate discharge planning conflicts should incorporate both micro and macro level skills. This is because discharge planning conflicts arise from a complex mix of factors; emotional reactions to illness and pressure exerted on patients, families and hospital staff by administrative regulations and cost containment efforts (Donnelly, 19992; Abramson, Donnelly, King & Mailick, 1993; Berkman, 1996; Fein, 1995). Therefore, it seems imperative to educate hospital social workers about the use of both micro and macro level interventions which integrate empowerment and political advocacy. This perspective may help social workers to feel energized in their efforts to change those aspects of the current health care system which are contributing to Role Overload and eroding their feelings of Job Satisfaction.

Implications for future research

These findings suggest that future research is needed on how social workers receive training to handle discharge planning conflicts and what this training entails. This study did not delve into the details of the training experience yet this would seem crucial as social workers With Training who experienced Role Overload had a greater potential for lower levels of Job Satisfaction than social workers Without Training who experienced Role Overload. This further suggests that research is also needed to

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understand what motivates health care social workers to obtain additional training, whether this is mandated in-service training at their job, where the training is obtained, its' content and duration.

Research Question 6

Research Question 6 concerns relationships between Social Support, Role Boundary and Burnout.

Research Question 6

Among those reporting a high degree of Social Support (SOST), there will be a negative relationship between Role Boundary (RBST) and Burnout. This relationship will not be observed among the respondents with low Social Support.

Measures used

Social Support (SOST), Role Boundaries (RBST) and Burnout (BURN) were all measured as was previously described in prior hypothesis and the section on the instrument.

Procedures used and results obtained

This hypothesis was tested using correlational analyses. Results of testing this hypothesis are as follows :

(1) There were 318 respondents reporting high Social Support and scores on Role Boundary and Burnout which were correlated $r = .32$ ($p < .05$). This means that among social workers with a high degree of Social Support, and who also report more concern with Role Boundaries, there are less frequent occurrence of symptoms of Burnout.

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(2) The 32 social workers reporting low Social Support had scores on Role Boundary and Burnout which were correlated $r = .44$ ($p < 05$). This means that social workers with low Social Support and who report more frequent concerns with Role Boundary, will have more frequent occurrences of Burnout. It should be noted that because of the small sample size, the correlation is not significantly different from (0).

Discussion

The preceding data analysis has found that a larger degree of Social Support does seem to ameliorate the potential effects of concern with Role Boundaries on the occurrence of Burnout. Prior to discussing this finding, it is important to note there are many measures of social support based on differing constructs of this phenomenon (Hobfoil & Vaux, 1993).

In this study, Social Support was defined as a coping resource emphasizing relationships with family and friends as well as social groups. The Social Support Scale therefore measured the extent to which the individual felt support and help from those around him/her. High scorers report feeling there is at least one person they can count on who values and/or loves them. They also may report having sympathetic people to talk to about work problems, having help to do important things and/or things around the house and feeling close to another individual (Osipow & Spokane, 1981).

Prior research on job stress and coping has examined factors both in the work setting and in the individual's life outside of work that may influence one's reaction to work - related stress. Evidence about the relationship among work stressors, social support and stress has been inconsistent, but strong perceptions of the buffering role of

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social support still persist (Pines & Kafry, 1989; Pearlin, 1989; Hemmelgarn & Laing, 1991; Hoppe, 1990).

The results of this study support perceptions that social support tends to ameliorate the effects of occupational stress (in this case, Role Boundary) on the occurrence of Burnout. Of interest in this study, is that the Social Support measure is highly skewed so that the group reporting lower levels of support has only 32 members. This skew towards greater degrees of social support may be a reflection of the sample having a majority of married individuals (60%) and women (84%). The relationship of marital status to burnout will be discussed in greater detail, but prior research suggests that married human service workers experienced less emotional exhaustion than those who were single or divorced (Maslach & Jackson, 1981; Siefert, Jayarante & Chess, 1991; Ratliff, 1988).

As well, gender differences have been observed in the use and benefit of social support. It has been suggested that women are more involved than men in social support interactions with additional evidence that women are more adept than men in the support process. This may help to explain women's greater intimacy with others and their larger support networks. Compared to men, women have been found to spend more time interacting with others in their social networks and sharing feelings and personal concerns (Hobfoil & Vaux, 1993).

The findings of this study are consistent with prior research on human service workers where the relationship between social support, work stress and burnout were also

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explored. In these studies, social support from intimate relationships, supervisors and other staff were discussed.

In their 1993 study, Hobfoil and Vaux reported that intimate relationships provided more support than those more distant because individuals felt as if the event was happening to them (Hobfoil & Vaux, 1993). This may help explain why marital satisfaction is found to be one of the most significant predictors of job satisfaction and why single or divorced human service workers feel more emotionally exhausted from their work that do married individuals (Maslach & Jackson, 1981; Siefert, Jayaratne & Chess, 1991; Ratliff, 1988).

Close relationships providing high levels of social support may also occur with others who are not marital partners. Cherniss (1980) interviewed social workers as part of a study on burnout in new professionals. One social worker described in detail how she was able to dissipate her emotional exhaustion at the end of each work day through the acceptance, sympathy and helpful suggestions from the person she was dating and her friends. The personal comments of that human service worker and others, further suggest that significant personal relationships help alleviate the strain of work.

Social support which occurs in the workplace from supervisors and other staff has also been the focus of study. Cherniss (1980) reports that one important way supervisors help to alleviate burnout is through being responsive to staff. He writes:

> One of the underlying causes of burnout is a sense of helplessness, a belief that one's responses have no effect on important sources of reinforcement. When supervisors are unresponsive they unwittingly foster this condition. However, if

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supervisors are available, interested and involved with their staff, then staff perceive a connection between what they do and an important source of reinforcement in the environment. (p. 117)

Research on child welfare workers does suggest that social workers may look to their supervisors to provide them with the needed emotional support when troubled at the job and this may buffer against the effects of burnout (Jayaratne & Chess, 1986). Research on a general population of social service workers also found that a positive social milieu, including social feedback from supervisors and other staff, seemed to provide the individual with support systems that serve as a protective buffer against job stresses (Pines & Kafry, 1978). Staff in human service agencies who are able to regularly meet with others in a "support group" have been found less likely to experience symptoms of Burnout (Pines, 1993; Maslach, 1981; Cherniss, 1980).

Implications for future research

This findings of this study are consistent with prior research which also found that social support can providing a buffering effect to ameliorate the effects of work strain. However, there are many different measures of and constructs for social support (Hobfoil & Vaux, 1993) which are broader in scope than the one used in this study. Here, one aspect of social support was studied; coping behavior which emphasized relationships with family, friends and social groups. Future research might address the relationship of Social Support to Role Boundary and Burnout when the former includes additional coping behaviors; self care, cognitive skills and recreational activities (Osipow & Spokane, 1981).

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The degree of skew towards high levels of social support in a sample with a high percentage of married individuals (60%) and women (84%), suggest this sample may have been biased towards individuals who obtained higher levels of social support and were receptive to receiving help. Future research might sample larger numbers of unmarried individuals and men in order to gain further information on how these populations perceive their level of social support and the relationship to occupational stress and burnout.

Finally, an important area for future research would require that a sample contain members of different ethnic/racial groups in order to examine the relationship between social support, occupational stressors and burnout among these populations. Such comparison was not possible in this study because the majority of social workers (90%) identified their ethnic/racial origin as Caucasian. Race may play a role in social network orientation with some theorists suggesting that communal orientation is more consistent with an Africentric than a Eurocentric viewpoint (Hobfoil & Vaux, 1993).

Summary

The following summarizes the results of the four hypotheses which were accepted either fully or partially.

- Social workers who have positive Attitudes towards Discharge Planning will report greater Job Satisfaction and less frequent occurrence of the symptoms of Burnout. A high degree of Burnout is also related to low levels of Job Satisfaction (Research Question 1).

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- Use of an Integrating Style of Handling Conflicts with other professional staff involved in discharge planning conflicts is positively related to social workers' Job Satisfaction. However, use of an Integrating Style of Handling Conflict with clients and client's families was not found to be a significant predictor of Job Satisfaction. As well, use of a Compromising Style of Handling Conflict with other professional staff, clients and clients' families was not found to be a significant predictor of Job Satisfaction (Research Question 3).
- Those social workers who were less troubled by Role Boundary concerns had greater Job Satisfaction (Research Question 4).
- Social workers Without Training over the past year in mediating discharge planning conflicts, have the potential for Role Overload issues to negatively effect their level of Job Satisfaction. However, social workers With Training and incidences of Role Overload had levels of Job Satisfaction lower than the group Without Training (Research Question 5).
- A larger degree of Social Support does seem to ameliorate the potential effects of social workers' concern with Role Boundaries on the occurrence of the symptoms of Burnout (Research Question 6).

The following summarizes the two hypotheses which were rejected either fully or partially..

- There are no differences in Styles of Handling Conflict which arise in discharge planning attributable to gender (Research Question 2).

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- The occupational stressor Role Overload and stress modifiers (Training in mediating discharge planning conflicts, Social Support) were not found to have significant effects on outcomes (Job Satisfaction, Burnout) or outcomes through stress modifiers (Research Question 4).

The means of the prorated scores yielded valuable information about this sample of health care social workers. The group was centrally positioned with regard to overall concern about Role Overload and Role Boundary problems. These social workers also tended to prefer an Integrating Style over a Compromising Style for resolving discharge planning conflicts. They also reported very high levels of Social Support, were above the midpoint in Job Satisfaction and reported symptoms of Burnout less than once a month. Their Attitude towards Discharge Planning was found to be undecided, but leaned towards agreement regarding its importance as a function for hospital social workers.

Finally, many social workers in this sample reported frequent Role Boundary and Role Overload concerns which reflected the strain of working in a host institution during a period of rapid change and emphasis on cost containment. This quantitative data was grounded in the day to day experiences of hospital social workers through the written comments provided by 75 (19%) of those sampled.

There were three major themes reflected in these comments: pressures imposed on social workers from prospective payment systems and managed care to discharge patients quickly (leaving little time for patient/family counseling and education), the negative impact of hospital downsizing on staffing and increased competition between social workers and nurses for dominance in the role of discharge planner.

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The implications of these findings for developing training for health care social workers in mediating discharge planning conflicts will be the focus of the concluding chapter.

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Chapter 5

CONCLUSION AND COMPONENTS OF A FRAMEWORK FOR TRAINING HEALTH CARE SOCIAL WORKERS IN MEDIATING DISCHARGE PLANNING CONFLICTS

Studying the mediator role that health care social workers play in discharge planning conflicts provides one with a lens. Through it, a glimpse is caught of the rapidly changing health care environments' impact upon social workers who have traditionally struggled in a host institution to define their role and status (Dane & Simon, 1991; Ingelhart, 1990; Davidson, 1990).

The voices of health care social workers participating in this study were expressed both through their responses to quantitative measures and many sensitive and thoughtfully written comments. From the frontlines of health care, these social workers spoke of caring and concern for patients and families devastated by the catastrophic toll of illness and disability. But they also spoke of efforts to provide support and assistance in a health care environment which places strong emphasis on cost containment efforts; often at the expense of allocating the time and resources needed to develop and implement optimal discharge plans (Fein, 1995).

The impact of the larger health care climate on health care social workers was clearly reflected in their attitudes towards discharge planning, role boundary and role overload concerns as well as their written comments. When developing a framework for training for health care social workers it is relevant to note that this sample perceived discharge planning as being very stressful (73%) and that there was not enough time in order to complete all the tasks which it entailed (65%). As well, many of these social

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workers (35%) felt: conflict between what their employer expected them to do and what they considered right and proper, caught between factions at work (40%) and experiencing divided loyalties on the job (42%). Yet, the majority (55%) did not prefer to be in a job which did not involve discharge planning and found it to be a very rewarding activity (58%).

These findings suggest that factors which include shorter lengths of stay, fewer options for aftercare (Fein, 1995), heavier caseloads with more complex and demanding cases (Siefert, Jayaratne & Chess, 1991), increased competition between social work and nursing for the primary role as discharge planner (Ingelhart, 1990; Freeman, 1992; Cowles & Lefcowitz, 1992; Kulys & Davis, 1987; Egan & Kadushin, 1995), managed care and the downsizing of many hospitals (Globerman, Davies & Walsh, 1996; Berger, Cayner, Jensen, Mizrahi, Scensny & Tractenberg, 1996; Ross, 1993; Cornelius, 1994; Cowles & Lefcowitz, 1992) have taken their toll on this sample of health care social workers. Yet, as many reported in their comments, they still found discharge planning to provide opportunities for using special skills, expertise and deriving intrinsic rewards. These conflicted reactions, negative attitudes in conjunction with feeling gratified, are consistent with prior research on occupational stress in health care social workers (Dillon, 1990; Taylor-Brown, Johnson, Hunter & Rockowitz, 1982).

The current health care environment is rapidly changing as illustrated by the factors described above. Therefore, in order to function effectively health care social workers are required to demonstrate substantial knowledge, skills and flexibility. When discussing how

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social work practice in health care must look to the future, Volland (1996) echos the importance of this perspective when she writes:

> Social work in health care has increasingly been defined by events and boundaries set by the health delivery system in which practice occurs. The host for the practice of social work in health care - the acute care hospital - is in turmoil. The current intent of health systems change is to drastically reduce the system's reliance on acute care hospitals. Indeed, the host is searching for a way to reshape its system of care - a system that is considered costly and does not effectively meet the needs of the medically ill now, nor will in the future. (p. 37)

Therefore, the goal of this framework is to help professional social workers master the rapidly changing health care environment. Social workers must reposition themselves in this new reality in order to succeed in their practice and to help their clients' adjustment. In order to reposition and accomplish this, the social work role must be redefined to function in a health care environment where departments of social work are moving away from linear management. Self managed teams will become more common, inpatient staff will be reduced as the number of inpatient beds decrease and the focus of care shifts from inpatient to ambulatory care (Berkman, 1996). A challenge for social work is to develop specialized advanced health curricula which meets the needs of continuously changing roles and practices in health care (Berkman et al. 1996; Christ, 1996).

Training to help health care social workers mediate discharge planning conflicts provides an ideal vehicle for helping them to master the current health care environment. Disagreements in discharge planning are frequent situations in health care with a variety of

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factors causing and contributing to their onset. These include patient and families' emotional reactions to illness and disability, pressure for quick discharges which may cut short the decision making process leaving patients and families to struggle with guilt, grief and post-decision regret, limited options for post hospital care and minimal involvement of patients and families in making the discharge plans (Donnelly & King, 1990; Donnelly & Siegel, 1993; Abramson, 1985; Abramson, Donnelly, King & Mailick, 1993). The convergence of these social, psychological and economic forces provide opportunities for learning which address the complex dimensions of the larger, rapidly changing health care environment.

Based upon the results of this study and prior social work research it is suggested that components for a contemporary framework should include: an understanding of health care economics; overview of mediation interventions; an examination of stress reduction techniques; empowerment and political advocacy skills.

Understanding health care economics

Managed care is rapidly becoming the predominant method of financing and delivering health care to the general public as well as Medicaid and Medicare recipients (Perloff, 1996; Berkman, 1996). Therefore, the implications throughout the country of the marriage of managed care to Medicaid and Medicare on the redesign of health and mental health care should be addressed. Other objectives of this topic would be to understand the forms that managed care plans and prospective payment systems take and their relationships to health care staffing, hospital downsizing, health care delivery systems and services for aftercare. Attention would be paid to how these cost containment efforts

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effect vulnerable and multi-need populations; e.g. the elderly, mentally ill and physically disabled (Cornelius, 1994; Mizrahi, 1993).

Information should be imparted to enable health care social worker's to actively participate in the debate surrounding managed care. Proponents of managed care argue that the system has effectively lowered health care costs while not reducing the quality of health care services. Advocates maintain that managed care encourages more efficient and less expensive medical care as well as stressing prevention over treatment. The health care system is therefore expected to be more efficient because doctors reimbursed by managed care operations have little incentive to "overtreat" patients and recommend unnecessary medical care (Karger & Stoesz, in press).

Understanding these systems is also complicated as managed care plans can take several different forms. First, they can take the form of Preferred Provider Organizations (PPOs) which are groups of doctors and hospitals that provide health care services at a fixed rate. The enrollee is given a list of providers from which they can choose a primary physician. Typically, the enrollee pays a modest co-payment. The second is a Point- of - Service (POS) plan which also includes a list of health care providers. However, patients may seek care outside of the network if they are willing to pay a higher share of the cost. The third option is a Health Maintenance Organization (HMO) which typically provides comprehensive health care for enrolled members (Karger & Stoesz, 1998).

Knowledge gained from understanding the rapidly changing scope and forces which shape and influence social workers' role and practice in the health care environment, may increase their feelings of having special expertise and therefore their

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sense of control. These are factors which have been positively associated with job satisfaction (Locke, 1976; Marriot, Sexton & Staley, 1994; Jayaratne & Chess, 1984)

Skill goals:

(1) Describe the different types of managed care plans.

(2) Describe threats and opportunities in managed care for social workers and their clients.

(3) Describe at least three key recommendations to advocate to state policy makers about ways for improving managed care for Medicare and Medicaid recipients.

(4) Educate other professional staff, patients and their families about the what managed care is, the economics driving managed care and the influence of managed care in determining the length of stay and options for aftercare. This can be a very important skill, as this study found that factors frequently contributing to disagreements in discharge planning involved misunderstandings among the patient, family and/or hospital regarding the length of stay (77%) and the type and availability of services for post-hospital care (72%).

Overview of mediation interventions

The objectives of this topic would be to help social workers assess which conflicts are suitable for using the mediator role and how to integrate short term mediation interventions into their practice. Attention would be paid to using these techniques not only with patients but also with other professional staff (including managed care representatives).

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Findings from this study revealed that an Integrating Style of handling discharge planning conflicts with other professional staff was positively related to Job Satisfaction. An Integrating Style involves the exchange of information, examination of differences required to reach a solution acceptable to both parties and problem solving that may lead to creative solutions (Rahim, 1983). Integrative problem solving conflict resolution strategies are the goal of mediation. It is a basic problem- solving process applied to conflict resolution and therefore is a familiar framework to social workers (Parsons, 1991). In the process of using it, opportunities may develop for positive interdisciplinary collaboration and recognition. Social workers are also given opportunities to use their valuable skills, abilities and encounter situations for new learning. These are all work attributes that have been found to positively contribute to job satisfaction (Locke,1976; Marriot, Sexton & Staley, 1994; Jayarante & Chess, 1984).

Information should also be provided which promotes understanding of how the mediator role differs from the therapist or advocate roles also enacted by social workers in the health care setting. In the mediator role, the social worker promotes reconciliation, settlement, compromise or understanding among two or more conflicting parties (Dworkin, Jacob & Scott, 1990, Gold, 1985, Parsons, 1991). In the advocate role, the social worker acts and/or on behalf of clients to obtain services and resources that would not otherwise be provided. Serving as an advocate for a client or group of clients has been a role assumed by social workers since the inception of the profession. Finally, in the therapist role assistance is provided to help clients more effectively cope with problems of living and improving the quality of their lives. Such work with individuals, families, groups

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and/or other systems draw on contrasting theories of human behavior, use different models of practice, implement diverse interventions and serve widely varying clients. (Hepworth, Rooney & Larsen, 1997). Social workers can apply their knowledge of mediation techniques through role plays based on cases developed from actual practice experiences involving discharge planning conflicts. A framework for the interventions for use with patients, families and/or other professional staff includes the following:

(a) Separate the people from the problem;

(b) Focus on interests instead of positions;

(c) Create options that satisfy the interests of the participants;

(d) Select criteria for choosing alternatives (Parsons, 1991, 1993, 1993; Fisher, Ury & Patton, 1981; Hocker & Wilmont, 1995)

Ethical dilemmas relating to the mediator role would also be addressed. The boundaries between mediation and therapy would be discussed in relation to ethical dilemmas. These include questions such as whether or not a mediator may ethically mediate with a couple after having functioned as therapist for one or both parties (Dworkin, Jacob & Scott, 1990). Mediation has also traditionally emphasized the bias-free stance of the mediator. The value base of social work is strongly articulated and interventions have a definite set of values: the promotion of individual differences and uniqueness, the promotion of social justice and optimal opportunity for capacity development. Therefore, complete neutrality conflicts with the value base of practice and the social work mediator is not an objective, disinterested non-biased third party intervener. Rather, a role is taken to help bring problems and issues to the bargaining table

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and to promote communications toward resolution within the value base of the profession (Parsons, 1991).

Social workers would be also encouraged to maintain an ongoing awareness of the hierarchal issues unique to negotiating in a health care environment and possible influences of gender on their interventions. Health care social workers have traditionally lacked formal authority, as resident guests in a host setting, to impose orders or decisions upon other professional staff, patients or patients' families (Dane & Simon, 1991; Dillon, 1990). The relationships between styles of handling conflict and gender are complex (Hocker & Wilmont, 1995; Berryman-Fine & Brunner, 1987; Lackoff, 1975; Miller, 1991; Warfel, 1984) but this study implies that health care social workers' style of handling disagreements in discharge planning may be more strongly influenced by their position in the medical hierarchy and their professional training than by their gender.

During all stages of the discharge planning conflict, social workers will need to be aware of how the medical setting intimidates patients and their families. There are tremendous imbalances of power and education which also separate patients and families from staff. The Montefiore Medical Center Bioethics Mediation Project stresses the necessity of those enacting the mediator role to prevent the staff from "ganging up" on the patient and family and to provide the "time outs" needed in order for a principled resolution to occur (Dubler & Marcus, 1994). It is a challenging endeavor to safeguard the conflict resolution process in the pressured world of health care especially as time is not an abstraction; it is measured in moments when a life can be saved and in colossal

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dollars spent when a delay occurs in discharging a patient who need not be in the hospital (Marcus et al., 1995).

Skill goals:

(1) Describe the difference between the therapist, advocate and mediator roles.

(2) Discuss ethical dilemmas which may arise when enacting the mediator role related to conflicts between the concept of a neutral, third- party intervener and the value base of social work practice.

(3) Discuss which conflict situations are appropriate for mediation and which are not.

(4) Identify ways in which the medical hierarchy may intimidate patients and families and describe social work interventions (e.g. patient/family education, supporting efforts at conflict resolution) which may help empower patients/families to cope with these realities.

(5) Using an example of a discharge planning conflict experienced in your practice as a health care social worker, discuss how you would: separate the people from the problem; focus on interests instead of positions; create options that satisfy the interests of the participants; select your criteria for generating options.

Stress reduction techniques

Findings from this study revealed that the majority of health care social workers in this sample found discharge planning to be very stressful (73%) and there was not enough time to complete all the tasks which it entailed (65%). Regardless of whether social workers reported having had training in mediating discharge planning conflicts, they still had the potential for Role Overload issues to negatively affect their level of job satisfaction

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(Research Question 5). Role overload is concerned with the extent to which demands exceed resources and the extent to which the individual is able to accomplish expected work loads (Osipow & Spokane, 1981).

Prior social work research has noted the stress associated with health care social work (Dillon, 1990; Taylor-Brown, Johnson, Hunter & Rockowitz, 1982; Jayaratne & Chess, 1986; Ratliff, 1988; Jones, Fletcher & Ibbetson, 1991). Dillon, through the use of humor, described the stress experienced by many health care social workers:

> Few careers serve up more predictable, unrelenting stress than social work in health settings...the health care social worker is constantly moving on a moment's notice between potentially conflicting roles, statuses, functions and contexts. By week's end the social worker will have transmuted herself many times as broker, enabler, midwife, factotum. Negotiating these palpable changes in the use of self will have required the skills of a ballerina, a football tackle, a Salvadoran diplomat. (p. 91)

Prior to being introduced to various stress reduction techniques, health care social workers should be provided with an overview on stress and burnout. A strong case has been made in the literature for a positive relationship between stress and burnout (Jayaratne & Chess, 1986; Maslach & Jackson, 1981,1986; Cherniss, 1980; Pines. 1993).It is hoped that having this information might help normalize the reactions of social workers who find themselves working in the stressful and rapidly changing health care environment.

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Stress management has been extensively discussed in the human service literature and is often presented as a way to cope with burnout (Potter, 1987; Cherniss, 1980; Pines, 1993; Ratliff, 1988; Taylor-Brown, Johnson, Hunter & Rockowitz, 1982; Dillon, 1990; Jones, Fletcher & Ibbetson, 1991). Burnout—a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment—can occur among professionals who engage in "people work" of some kind. (Maslach & Jackson, 1981,1986; Cherness, 1980).

It has been suggested that a certain degree of burnout is inevitable in any health and human service worker, and this takes a terrible toll on the professional, client and organization (Maslach & Jackson, 1981,1986; Ratliff, 1988; Cherniss, 1980). In this study, the negative impact of burnout was also reported. It was found (Research Question 1) that social workers who report frequent symptoms of burnout will have a more negative attitude towards discharge planning and report low levels of job satisfaction. The challenge thus lies in finding ways to cope with occupational stress and burnout so that workers can use these experiences to grow and renew themselves (Ratliff, 1988; Potter, 1987).

There have been contradictory findings about gender-related work stress. An awareness of this research is especially important for those in a profession composed primarily of women; as was reflected in this preceding random, national survey of inpatient health care social workers where 84% were women. Another study found that compared to professional men, professional women experienced four times the amount of job tedium; felt they had less job freedom, autonomy, influence, variety and challenge in their

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job. These women professionals also believed their work environment was less positive (Pines, Aronson & Kafry, 1981). Other researchers reported that women therapists experienced greater levels of stress and emotional exhaustion than did their male counterparts (Maslach, 1981; Ratliff, 1988). However, another study suggested that employment outside the home may protect women from coronary heart disease (Hazuda et al.,1986). Finally, a three - generational study of women in Mexican-American families found that employment had generally positive psychological effects (Krause & Markides, 1985).

It is suggested that an explanation for these contradictory findings on the effect of employment on womens' well-being may be found in a synthesis of role conflict and power perspectives. Effects of employment for women are not consistently positive because they involve trading one source of low control for another. Thus, in situations of low demands (no children or help from the spouse with child care) employed women have symptoms of stress equal to those of men and significantly lower than housewives (Rosenfield, 1989).

Finally, it is important for social workers to develop the ability to identify where the source of stress is coming from. Sources of burnout may arise from the organizational design with three components noted to be most important; role structure, the power structure and the normative structure (Cherniss, 1980; Jayaratne & Chess, 1986; Taylor-Brown, Hunter & Rockowitz, 1981).

Another source of stress is being in the human service professions; there is often a lack of criteria for measuring accomplishments coupled with performance of work that is

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emotionally demanding and draining (Pines, Aronson & Kafry, 1981; Ratliff, 1988; Taylor -Brown, Hunter & Rockowitz, 1981).Finally, there may be individual factors which contribute to stress. These include personality traits (e.g. being neurotically anxious), career - related goals and attitudes, sex role stressors (Dillon, 1990; Pines, Aronson & Kafry, 1981; Ratliff, 1988) and ones' degree of social support (Cherniss, 1980, Ratliff, 1988; Pines, 1993

The above overview on occupational stress and burnout helps provide a context for stress reduction techniques suggested by the literature. It is important to keep in mind that any worker or group of workers will have unique needs, preferences, abilities and fears. Therefore, a strategy for alleviating stress and burnout might work in one situation, it could be disastrous in another (Cherniss, 1980). Commonly recommended interventions are as follows:

- Life enrichment through meaningful interpersonal relationships

  This study found that social support tends to ameliorate the effects of occupational stress (in this case, role boundary concerns) on the occurrence of burnout (Research Question 6). This finding was consistent with prior research on human service workers which also found that social support can provide a buffering effect to ameliorate the effects of work strain (Jayaratne & Chess, 1986; Pines & Kafry, 1978; Pines, 1993; Maslach & Jackson, 1981; Cherniss, 1980).

- Organizational strategies

  Strategies for decreasing stress and preventing burnout in the workplace include the following: staff development (e.g. providing opportunities for developing new

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skills and knowledge by way of workshops, attendance at professional conferences and continuing education, teach coping strategies such as time management techniques); changing jobs and work structure (e.g. limit caseloads, encourage staff to take frequent "time outs" and vacations); management development (e.g. monitor role strain in supervisors and intervene when this becomes excessive); organizational problem - solving and decision - making (e.g. create formal mechanisms for group and organizational problem solving and dispute resolution); refinement of agency goals and guiding philosophies (e.g. make agency goals and philosophies as clear as possible) (Cherniss, 1980; Pines, 1993; Jones, Fletcher & Ibbetson, 1991).

- Personal therapy

Personal therapy may help the harried health care social worker to become aware of and change certain unhelpful cognitions; such as self defeating ideas. Doing so is important for these negative thinking patterns may exacerbate reactions to occupational stress and increase the frequency of symptoms of burnout (Dillon, 1981). Effective coping skills learned in therapy may positively affect one's cognitive assessment of a situation. While the social worker may not be able to change the stressors of his/her job, this may enable the establishment of new definitions of success that preserve a sense of control and positive self esteem (Ratliff, 1988) . The therapeutic relationship may also increase an individual's degree of social support. As discussed above, social support does seem to play a role in ameliorating the effects of occupational stress.

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- Yoga, meditation, physical exercise

  The literature suggests that these interventions may help reduce stress because they increase ones' repertoire of coping skills(Ratliff, 1988; Dillon, 1990; Potter, 1987; Taylor - Brown, Johnson, Hunter & Rockowitz, 1982). As with personal therapy, learning these new activities may also create positive personal change. Being able to effect change, whether on an individual and/or organizational level, reduces hopelessness and helplessness and consequently, burnout (Pines, 1993).

Skill goals:

(1) Describe the burnout syndrome and identify both organizational and individual factors contributing to its' onset in health and human service professionals.

(2) Discuss factors in your organization which contribute to burnout and discuss a range of interventions to alleviate them.

(3) Describe the wide range of stress reduction techniques useful for the individual health care social worker.

Empowerment and political advocacy skills

Qualitative data obtained from the health care social workers in this study revealed that their practice was often shaped by forces out of their control and emanating from changes in the current health care environment. Several wrote comments about the need for social workers to be more assertive in advocating for their role as discharge planners in order to remain viable in health care settings. There was also quantitative data which reported that these social workers had conflicted attitudes towards discharge planning (see Table 8) and experienced role boundary and role overload concerns.

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This data infers that many factors in the health care environment influenced the development of their negative attitudes, role boundary and role overload concerns. These include shorter lengths of hospital stay and fewer options for aftercare (Fein, 1995); increased competition between social work and nursing (Ingelhart, 1990; Freeman, 1992; Cowles & Lefcowitz, 1992; Kulys & Davis, 1987; Egan & Kadushin, 1995); managed care and the downsizing of many hospitals (Globerman, Davies & Walsh, 1996; Berger, Cayner, Jensen, Mizrahi, Scensny & Tractenberg, 1996; Ross, 1993; Cornelius, 1994; Cowles & Lefcowitz, 1992; Karger & Stoesz, 1998).

The overwhelming impact of the changing health care environment may engender feelings of helplessness in social workers who practice under these conditions. A sense of helplessness is a major underlying cause of burnout (Cherniss, 1980). However, the most effective way to cope with factors causing burnout is the use of an active change- oriented strategy. Active strategies, which include empowerment and political advocacy, help to decrease the symptoms of burnout because they promote change in the situation and/or individual. In many cases, positive change increases the likelihood that highly motivated social workers will find a sense of meaning in their work (Pines, 1993). Therefore, the importance of including these interventions in a training framework should not be underestimated.

Empowerment is a concept which has diverse definitions reflecting a wide range of viewpoints. Health care social workers should be challenged to reflect upon their practice, organization, the current health care environment and their personal experiences in order to arrive at a concept and definition relevant to them. Based on a synthesis of the

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literature, one definition of empowerment useful to health care social workers is as follows (Parsons, 1991):

> Empowerment is a process through which people become strong enough to participate within, share in the control of, and influence, events and institutions affecting their lives... empowerment necessitates that people gain particular skills, knowledge and sufficient power to influence their lives and the lives of those they care about. (p.11)

As well, information should be imparted to help further understand how empowering interventions would differ depending upon the level of intervention: individuals, groups, organizations and communities. At the individual level, empowerment focuses on promoting participatory behavior, skill acquisition and differing forms of self-efficacy attributions (e.g. self esteem) leading to an increased sense of personal control. At the group level, empowerment enhances cohesiveness, collective problem- solving skills, affiliate behavior and joint feelings of efficacy and control. Organizational empowerment includes shared leadership and opportunities to develop skills, expansion and effective community leadership. At the community level, empowerment includes opportunities for citizen participation in community decision making (Dunst, Trivette & LaPointe, 1994; Parsons, 1991; Gutierrez, GlenMaye & DeLois, 1995) .

Focus should be given to how these concepts apply in a health care setting. For example, patients and their families often feel disempowered by the intimidating nature of the hospital as well as the many emotional, social and economic losses associated with illness and disability. Clinical practice based on empowerment assumes that clients' power

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is enhanced when they have control over their lives and choices. To facilitate this social workers can help patients articulate the nature of their situations, identify what they want, explore options and how to achieve them. Social workers need to use their knowledge of power dynamics and systemic process to empower patients and families and educate them about the dynamics of power in their lives (Cowger, 1994; Gutierrez, 1994; Pinderhughes, 1983). Central to this, is having social workers focus on the strengths of patients and their families. A strengths perspective in assessment reinforces patient/family competence and helps to mitigate the significance of unequal power relationships between them and the hospital staff (Cowger, 1994).

Findings from this study highlight the necessity of including ways to make assessment an empowering intervention; 74% of these health care social workers reported that assessing the psychosocial functioning of the patient and/or family was a daily occurrence. This finding was echoed by Kadushin & Kulys (1993) who identified assessment as a core activity of health care social workers. In their study, health care social workers reported assessment tasks to be some of the most time consuming and important activities in discharge planning.

Skill goals:

(1) Discuss the concept of empowerment as it relates to your practice, organization and personal experiences.

(2) Using your practice setting, describe empowerment interventions applicable at the individual, group, organization and community levels.

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(3) Using a case from your practice which involved a discharge planning conflict, discuss ways in which disempowerment of the patient, family and/or staff may have contributed to the disagreement. Discuss empowering interventions which you used, or might have used in retrospect, to help resolve the conflict; these may have occurred at the individual, group, organizational or community levels.

This national survey of inpatient, health care social workers has helped to raise issues involving the social work profession's commitment to the goal of social justice and whether social change is fundamental to social work education (Fisher, 1995). These are significant points to consider when discussing the problems encountered by health care social workers in a period when managed care is clearly having an major impact in shaping American medicine. Data obtained from this sample allude to the negative repercussions many social workers experienced while struggling to maintain practices in health care settings while striving to provide quality assistance to patients and families.

Critics of managed care operations (including HMOs) maintain that these organizations are plagued with serious problems. These include making access to specialists difficult, reluctance to cover costly procedures, especially related to experimental cancer treatments. They also may fail to provide the same level of benefits as Medicare particularly when it comes to home health care, physical therapy and nursing home care (Karger & Stoesz, 1998).

Both clients and social workers have clearly suffered from this lack of workplace control and some contend that social work (like other professions) is deflecting its social justice mission onto narrower professional issues; e.g. licensure and third party payments

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for private practitioners (Fisher & Karger, 1997). If practitioners lose their identity as social workers, they also relinquish the concept of professional function. This may lead to the relegation of social policy and program development to other disciplines or to see those responsibilities as a separate part of the professional function. Social workers may then lose their understanding of the dual commitment to social service and social action (Kurzman, 1976).

Given that social work in health care has been increasingly defined by events set by the health care delivery system in which practice occurs (Volland, 1996), shunning this dual commitment can only lead to worsening conditions for health care social workers and the clients they serve. It therefore seems incumbent for social work education to address contemporary challenges based on its historical tradition of concern with the nature of power, ideology and social justice.

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APPENDIX A

LETTER SENT TO SUBJECTS

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Joanne Levine A.C.S.W., M.P.H.
200 East 33rd St. Suite 25A
New York, NY 10016

Dear Colleague,

I am a doctoral candidate in the D.S.W. program at the City University of New York Graduate Center-Hunter College School of Social Work. I am a practicing clinical social worker in a New York City hospital where I provide discharge planning services. You have been selected from a random sample of members belonging to the National Association of Social Workers who also practice in a medical/health care setting. Enclosed is a questionnaire addressing a topic of great concern to those of us who practice in health care today: disagreements in discharge planning.

As social workers, we are in the front lines with patients and families who struggle to make crucial decisions about aftercare. Unfortunately, the discharge planning process may be fraught with disputes and we play a pivotal role in mediating them. Our profession needs to understand more about how disagreements in discharge planning affect us: our morale, job satisfaction and feelings of stress on the job. Such knowledge may help us improve our practice as well as enhance our efforts to provide the very best in patient care. The information obtained from this study will provide the basis for development of a training program in coping with conflict in discharge planning.

Please take the time to fill out this important questionnaire. It is estimated to only take about 20 minutes of your time and is completely confidential. Only the aggregate data will be analyzed and discussed in my dissertation.

Thank you, in advance, for your time. Please feel free to contact me at the address above should you have questions, wish to discuss this in more detail, or would like to receive information on the outcome of this study when it is completed.

Sincerely yours,

Joanne Levine, A.C.S.W., M.P.H.

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APPENDIX B

QUESTIONNAIRE SENT TO SUBJECTS

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#_____

COPING WITH CONFLICT:

DISCHARGE PLANNING

Joanne Levine, A.C.S.W., ABD
200 E. 33rd Street, #25A
New York, NY 10016

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Additional Comments

Please feel free to write any additional comments about the role you play in mediating disagreements in discharge planning and/or what training might help you better fulfill this role.

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Work Setting

Please answer the following questions about your place of work:

What type of hospital do you work in? (Please check only one)

_____ (1) General	_____ (4) Rehabilitation	
_____ (2) Special	_____ (5) Chronic Disease	
_____ (3) Psychiatric		CH1

What is the auspice of your hospital? (Please check only one)

_____ (1) Government, non federal	_____ (4) Osteopathic	
_____ (2) Investor-owned (for profit)	_____ (5) Government, federal, not for profit	
_____ (3) Non-governmental, not for profit		CH2

Are you a member of a trade union?

Yes = 1 No = 0 CH3

What is the primary area in which you work? (Check only one answer)

_____ (1) Medical/surgical	_____ (4) OB-GYN	
_____ (2) Psychiatry	_____ (5) Rehabilitation	
_____ (3) Pediatrics	_____ (6) Other (please specify) ____________	CH4

What is the nature of your primary position? (Check only one answer)

_____ (1) Staff member	_____ (3) Administrator	
_____ (2) Supervisor	_____ (4) Other (please specify) ____________	CH5

How many hours per week do you work at your primary area of work?

_____ hours per week CH6

How long have you been at your present job?

_____ year(s) _____ month(s) CH7

How long have you been employed as a social worker?

_____ year(s) _____ month(s) CH8

Have you ever received any in-service and/or additional training to help you mediate conflicts which arise in discharge planning?

Yes = 1 No = 0 CH9

<u>If yes</u>:

In the past 1 year, about how many hours of training did you receive about mediating conflicts?

Number of hours _________ CH10

How much of your time is spent on discharge planning?

_____ (1) 25% or less	_____ (3) 51-75%	
_____ (2) 26-50%	_____ (4) 76-100%	CH11

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Discharge Planning: Disagreements

In those cases where disagreements occurred between key figures (patient, family and/or hospital staff) during the discharge planning process, which of the following factors have contributed? **PLEASE CHECK ALL THAT APPLY.**

_____	Unrealistic expectations about post-hospital planning by the patient's family/significant other.	CH12
_____	Emotional difficulty adjusting to illness/disability by the patient.	CH13
_____	Conflict between the patient and family about who will have the decision-making power about post-hospital care.	CH14
_____	Unrealistic expectations about post-hospital planning by the patient.	CH15
_____	Emotional difficulty adjusting to the illness/disability by the family/significant other.	CH16
_____	Misunderstandings among the patient, family and/or hospital staff regarding the length of stay.	CH17
_____	Conflict among the patient, family and/or hospital regarding the type and availability of services for post-hospital care.	CH18
_____	Ethical dilemmas caused by conflicts between the regulatory and organizational requirements of the hospital.	CH19
_____	Conflict between the patient, family and/or hospital staff regarding the post-hospital destination of the patient.	CH20
_____	Ethical dilemmas caused by conflicts between the patient's rights and the regulatory and organizational requirements of the hospital.	CH21

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Discharge Planning: Interventions

How often do you implement each of the following interventions as a discharge planner? **PLEASE WRITE IN THE NUMBER CORRESPONDING TO HOW OFTEN YOU USE EACH INTERVENTION.**

HOW OFTEN:

0	1	2	3	4	5	6
Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

HOW OFTEN 0-6	Statements:	
____	Assessing the psychosocial functioning of the patient and/or family.	CH22
____	Helping a family and/or patient plan for discharge.	CH23
____	Arranging home equipment for the patient.	CH24
____	Assessing the impact of illness on a patient's family/ significant other.	CH25
____	Arranging for placement in a nursing home after discharge.	CH26
____	Counseling an ill patient.	CH27
____	Counseling a family member about an ill family member.	CH28
____	Assessing the patient's need for home health services.	CH29
____	Helping a patient and/or family to understand insurance/costs of aftercare.	CH30
____	Other (please specify) ____________________	CH31

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Discharge Planning: Attitudes

Please circle the one response that best describes your attitude for the following statements:

1 Strongly Agree (SA)	2 Agree (A)	3 Undecided (UD)	4 Disagree (D)	5 Strongly Disagree (SD)

	SA	A	UD	D	SD	
Discharge planning is very rewarding.	1	2	3	4	5	CH32
I enjoy individual and/or family counseling more than discharge planning.	1	2	3	4	5	CH33
Discharge planning is the most important thing a hospital social worker does.	1	2	3	4	5	CH34
There is not enough time to complete all the tasks associated with discharge planning.	1	2	3	4	5	CH35
Discharge planning is very stressful.	1	2	3	4	5	CH36
Discharge planning is a real burden for me.	1	2	3	4	5	CH37
I'd rather be in a job where I did not have to do discharge planning.	1	2	3	4	5	CH38
I have to regularly stay late to complete the work related to discharge planning.	1	2	3	4	5	CH39
I wish other professional staff had a better understanding and/or appreication of my work in discharge planning.	1	2	3	4	5	CH40

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Job Attitudes

Read each statement carefully. **FOR EACH STATEMENT, CIRCLE THE NUMBER WHICH FITS YOU BEST.**

Circle (1) if the statement is **rarely** or **never** true.
Circle (2) if the statement is **occasionally** true.
Circle (3) if the statement is **often** true.
Circle (4) if the statement is **usually** true.
Circle (5) if the statement is true **most of the time**.

	Rarely True		Often True		True Most Of The Time	
My job requires me to work in several equally important areas at once.	1	2	3	4	5	CH41
I am expected to do more work than is reasonable.	1	2	3	4	5	CH42
I feel overqualified for my job.	1	2	3	4	5	CH43
I have to perform tasks that are beneath my ability.	1	2	3	4	5	CH44
My supervisor provides me with useful feedback about my performance.	1	2	3	4	5	CH45
My supervisor asks for one thing but really wants another.	1	2	3	4	5	CH46
I have a clear understanding of how my boss wants me to spend my time.	1	2	3	4	5	CH47
I feel conflict between what my employer expects me to do and what I think is right or proper.	1	2	3	4	5	CH48
I feel caught between factions at work.	1	2	3	4	5	CH49
My supervisors have conflicting ideas about what I should be doing.	1	2	3	4	5	CH50
It is clear who really runs things where I work.	1	2	3	4	5	CH51
I have divided loyalties on my job.	1	2	3	4	5	CH52
I spend time concerned with the problems others at work bring to me.	1	2	3	4	5	CH53
I worry about whether the people who work for/with me will get things done properly.	1	2	3	4	5	CH54
People who work for/with me are really hard to deal with.	1	2	3	4	5	CH55
At work. I am expected to do too many different tasks in too little time.	1	2	3	4	5	CH56
I feel caught between patient/family and hospital staff	1	2	3	4	5	CH57
I feel angry when I have to mediate difficult disputes between patient/family and hospital staff	1	2	3	4	5	CH58

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Job Attitudes

Read each statement carefully. **FOR EACH STATEMENT, CIRCLE THE NUMBER WHICH FITS YOU BEST.**

Circle (1) if the statement is **rarely or never** true.
Circle (2) if the statement is **occasionally** true.
Circle (3) if the statement is **often** true.
Circle (4) if the statement is **usually** true.
Circle (5) if the statement is true **most of the time.**

	Rarely True		Often True		True Most Of The Time	
I feel that my job responsibilities are increasing.	1	2	3	4	5	CH59
I am expected to perform tasks on my job for which I have never been trained.	1	2	3	4	5	CH60
I have to take work home with me.	1	2	3	4	5	CH61
I work under tight time deadlines.	1	2	3	4	5	CH62
I wish that I had more help to deal with the demands placed upon me at work.	1	2	3	4	5	CH63

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Job Satisfaction

Please rate each of the aspects of your work listed below according to the **degree of satisfaction or dissatisfaction** it provides you. Circle a number between 1 (Very Dissatisfied) and 11 (Very Satisfied) for each aspect.

	Very Dissatisfied (-)										Very Satisfied (+)	
Working with your clients	1	2	3	4	5	6	7	8	9	10	11	CH64
The amount of authority you have been given to do your job	1	2	3	4	5	6	7	8	9	10	11	CH65
Interpersonal relations with fellow workers	1	2	3	4	5	6	7	8	9	10	11	CH66
Your salary and benefits	1	2	3	4	5	6	7	8	9	10	11	CH67
Opportunities for promotion . . .	1	2	3	4	5	6	7	8	9	10	11	CH68
The challenge your job provides .	1	2	3	4	5	6	7	8	9	10	11	CH69
The quality of supervision you receive	1	2	3	4	5	6	7	8	9	10	11	CH70
Chances for acquiring new skills	1	2	3	4	5	6	7	8	9	10	11	CH71
Amount of client contact	1	2	3	4	5	6	7	8	9	10	11	CH72
Opportunities for really helping people	1	2	3	4	5	6	7	8	9	10	11	CH73
Amount of funding for programs .	1	2	3	4	5	6	7	8	9	10	11	CH74
Clarity of guidelines for doing your job	1	2	3	4	5	6	7	8	9	10	11	CH75
Opportunity for involvement in decision making	1	2	3	4	5	6	7	8	9	10	11	CH76
The recognition given your work by your supervisor	1	2	3	4	5	6	7	8	9	10	11	CH77
Your feeling of success as a professional	1	2	3	4	5	6	7	8	9	10	11	CH78
Field of specialization you are in	1	2	3	4	5	6	7	8	9	10	11	CH79
The amount of personal growth and development you get from doing your job	1	2	3	4	5	6	7	8	9	10	11	CH80
Amount of support from agency . .	1	2	3	4	5	6	7	8	9	10	11	CH81

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Discharge Planning: Conflict Management

Now I have three sets of questions related to conflict management with other professional staff, clients' families, and with clients.

Conflict Management: Other Professional Staff

You may have incompatibilities, disagreements, or differences (i.e. conflicts) with other professional staff about discharge planning. Rank each of the following statements to indicate **how you handle your conflict with other professional staff.** Try to recall as many recent conflict situations as possible in ranking these statements. Circle the number of the response that fits you best.

There are no right or wrong answers. The response which is most characteristic of your behavior, in a situation of conflict with other professional staff, is the best answer. Any other answer which may be considered as more desirable or acceptable will simply lead to misleading information.

1	2	3	4	5
Strongly Agree (SA)	Agree (A)	Undecided (UD)	Disagree (D)	Strongly Disagree (SD)

	SA	A	UD	D	SD	
I try to investigate an issue with other professional staff to find a solution acceptable to us.	1	2	3	4	5	CH82
I try to integrate my ideas with those of other professional staff to come up with a decision jointly.	1	2	3	4	5	CH83
I try to work with other professional staff to find solutions to a problem which satisfy our expectations.	1	2	3	4	5	CH84
I usually avoid open discussions of my differences with my other professional staff.	1	2	3	4	5	CH85
I use my authority to make a decision in my favor.	1	2	3	4	5	CH86
I negotiate with other professional staff so that a compromise can be reached.	1	2	3	4	5	CH87
I use "give and take" so that a compromise can be made.	1	2	3	4	5	CH88
I am generally firm in pursuing my side of the issue.	1	2	3	4	5	CH89
I collaborate with other professional staff to come up with decisions acceptable to us.	1	2	3	4	5	CH90
I try to keep my disagreement with other professional staff to myself in order to avoid hard feelings.	1	2	3	4	5	CH91
I try to work with other professional staff for a proper understanding of a problem.	1	2	3	4	5	CH92

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Conflict Management: Families of Clients

You may have incompatibilities, disagreements, or differences (i.e. conflicts) with the family of your patients about discharge planning. Rank each of the following statements to indicate **how you handle your conflict with the families of your patients**. Try to recall as many recent conflict situations as possible in ranking these statements. Circle the number of the response that fits you best.

There are no right or wrong answers. The response which is most characteristic of your behavior, in a situation of conflict with the family of your patients, is the best answer. Any other answer which may be considered as more desirable or acceptable will simply lead to misleading information.

1	2	3	4	5
Strongly Agree (SA)	Agree (A)	Undecided (UD)	Disagree (D)	Strongly Disagree (SD)

	SA	A	UD	D	SD	
I try to investigate an issue with the family to find a solution acceptable to us.	1	2	3	4	5	CH93
I try to integrate my ideas with those of the family to come up with a decision jointly.	1	2	3	4	5	CH94
I try to work with the family to find solutions to a problem which satisfy our expectations.	1	2	3	4	5	CH95
I usually avoid open discussions of my differences with the family.	1	2	3	4	5	CH96
I use my authority to make a decision in my favor.	1	2	3	4	5	CH97
I negotiate with the family so that a compromise can be reached.	1	2	3	4	5	CH98
I use "give and take" so that a compromise can be made.	1	2	3	4	5	CH99
I am generally firm in pursuing my side of the issue.	1	2	3	4	5	CH100
I collaborate with the family to come up with decisions acceptable to us.	1	2	3	4	5	CH101
I try to keep my disagreement with the family to myself in order to avoid hard feelings.	1	2	3	4	5	CH102
I try to work with the family for a proper understanding of a problem.	1	2	3	4	5	CH103

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Conflict Management: Clients

You may have incompatibilities, disagreements, or differences (i.e. conflicts) with your clients about discharge planning. Rank each of the following statements to indicate **how you handle your conflict with your clients**. Try to recall as many recent conflict situations as possible in ranking these statements. Circle the number of the response that fits you best.

There are no right or wrong answers. The response which is most characteristic of your behavior, in a situation of conflict with your clients, is the best answer. Any other answer which may be considered as more desirable or acceptable will simply lead to misleading information.

1	2	3	4	5
Strongly Agree (SA)	Agree (A)	Undecided (UD)	Disagree (D)	Strongly Disagree (SD)

	SA	A	UD	D	SD	
I try to investigate an issue with my clients to find a solution acceptable to us.	1	2	3	4	5	CH104
I try to integrate my ideas with those of my clients to come up with a decision jointly.	1	2	3	4	5	CH105
I try to work with my clients to find solutions to a problem which satisfy our expectations.	1	2	3	4	5	CH106
I usually avoid open discussions of my differences with my clients.	1	2	3	4	5	CH107
I use my authority to make a decision in my favor.	1	2	3	4	5	CH108
I negotiate with my clients so that a compromise can be reached.	1	2	3	4	5	CH109
I use "give and take" so that a compromise can be made.	1	2	3	4	5	CH110
I am generally firm in pursuing my side of the issue.	1	2	3	4	5	CH111
I collaborate with my clients to come up with decisions acceptable to us.	1	2	3	4	5	CH112
I try to keep my disagreement with my clients to myself in order to avoid hard feelings.	1	2	3	4	5	CH113
I try to work with my clients for a proper understanding of a problem.	1	2	3	4	5	CH114

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Job Related Feelings

Below are statements of job-related feelings. Please read each statement carefully and decide if you ever feel this about your job. If you have never had this feeling, write "0" (zero) before the statement. If you have had this feeling, indicate how often you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

HOW OFTEN

0-6	Statement:
______	I feel depressed at work.

If you never feel depressed at work, you would write the number "0" (zero) under the heading HOW OFTEN. If you rarely feel depressed at work (a few times a year or less), you would write the number "1." If your feelings of depression are fairly frequent (a few times a week, but not daily), you would write a "5."

HOW OFTEN:

0	1	2	3	4	5	6
Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

---

HOW OFTEN

0-6	Statements:	
______	I feel emotionally drained from my work.	CH115
______	I feel used up at the end of the workday.	CH116
______	I feel fatigued when I get up in the morning and have to face another day on the job.	CH117
______	I can easily understand how my clients feel about things.	CH118
______	I feel I treat some clients as if they were impersonal objects.	CH119
______	Working with people all day is really a strain for me.	CH120
______	I deal very effectively with the problems of my clients.	CH121
______	I feel burned out from my work.	CH122

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Job Related Feelings

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HOW OFTEN

0-6	Statement:
______	I feel depressed at work.

If you never feel depressed at work, you would write the number "0" (zero) under the heading HOW OFTEN. If you rarely feel depressed at work (a few times a year or less), you would write the number "1." If your feelings of depression are fairly frequent (a few times a week, but not daily), you would write a "5."

HOW OFTEN:

0	1	2	3	4	5	6
Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

---

HOW OFTEN

0-6	Statements:	
______	I feel I'm positively influencing other people's lives through my work.	CH123
______	I've become more callous toward people since I took this job.	CH124
______	I worry that this job is hardening me emotionally.	CH125
______	I feel very energetic.	CH126
______	I feel frustrated by my job.	CH127
______	I feel I'm working too hard on my job.	CH128
______	I don't really care what happens to some clients.	CH129
______	Working with people directly puts too much stress on me.	CH130
______	I can easily create a relaxed atmosphere with my clients.	CH131
______	I feel exhilarated after working closely with my clients.	CH132
______	I have accomplished many worthwhile things in this job.	CH133
______	I feel like I'm at the end of my rope.	CH134
______	In my work, I deal with emotional problems very calmly.	CH135
______	I feel clients blame me for some of their problems.	CH136

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Social Supports

Read each statement carefully. For each statement, circle the number which fits you best.

Fill in (1) if the statement is **rarely** or **never** true.
Fill in (2) if the statement is **occasionally** true.
Fill in (3) if the statement is **often** true.
Fill in (4) if the statement is **usually** true.
Fill in (5) if the statement is true **most of the time**.

	Rarely True		Often True		True Most Of The Time	
There is at least one person important to me who values me.	(1)	(2)	(3)	(4)	(5)	CH137
I have help with tasks around the house.	(1)	(2)	(3)	(4)	(5)	CH138
I have help with the important things that have to be done.	(1)	(2)	(3)	(4)	(5)	CH139
There is at least one sympathetic person with whom I can discuss my concerns.	(1)	(2)	(3)	(4)	(5)	CH140
There is at least one sympathetic person with whom I can discuss my work problems.	(1)	(2)	(3)	(4)	(5)	CH141
I feel I have at least one good friend I can count on.	(1)	(2)	(3)	(4)	(5)	CH142
I feel loved.	(1)	(2)	(3)	(4)	(5)	CH143
There is a person with whom I feel really close.	(1)	(2)	(3)	(4)	(5)	CH144
I have a circle of friends who value me.	(1)	(2)	(3)	(4)	(5)	CH145

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Background Information About You

Please circle your response to the questions below.

What is your sex?

Male.........1
Female.......2 CH146

What is your date of birth? ____________ CH147
MO/DAY/YR

What is your marital status?

Married............................ 1
Widowed............................ 2
Separated.......................... 3
Divorced........................... 4
Never Married...................... 5
Other (Specify).................... 6
______________________________ CH148

Please check the highest degree you have received:

____ (1) BSW
____ (2) MSW
____ (3) DSW
____ (4) Ph.D. (specify) ________
____ (5) Other (specify) ________ CH149

Have there been any events (e.g., personal relationship problems, divorce, move) in your life during the past one year which have been disturbing to you?

____ Yes......1 ____ No......0

If yes (please write event):

What was the most disturbing? ______________________________

____

Anything else? ______________________________

____

Anything else? ______________________________

______________________________ CH150

How often do any of these events influence your behavior on the job? **(PLEASE CIRCLE THE BEST RESPONSE.)**

Rarely or never 1
Occasionally 2
Often 3
Usually 4
Most of the time 5 CH151

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Background Information About You

Have you ever been physically threatened during a disagreement about discharge planning?

Yes = 1 No = 0 CH152

If yes, please indicate how often you have been physically threatened over the past year:

____ (1) 1 time ____ (3) 6-10 times
____ (2) 2-5 times ____ (4) More than 11 times CH153

If yes, please indicate which participants in the discharge planning disagreement were physically threatening to you. Please check all that apply:

____ (1) Other professional staff ____ (3) Client's family
____ (2) Clients ____ (4) Other (specify)
____________________ CH154

How would you identify your ethnic/racial origin? **PLEASE CIRCLE ONE.**

American Indian (American Indian/Alaskan native) . . . 1
Asian or Pacific Islander 2
African American/Black (Non-Hispanic) 3
Chicano/Mexican American 4
Puerto Rican 5
Other Hispanic/Latino 6
White Caucasian (Non-Hispanic) 7
Mixed Heritage 8
Other (specify) ____________ 9 CH155

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Background Information About You

What is your native language?
(IF MORE THAN ONE, WHAT IS THE FIRST LANGUAGE YOU LEARNED?)

_____ Arabic.................................. 1
_____ Armenian................................ 2
_____ Asian Indian Languages.................. 3
_____ Chinese................................. 4
_____ Czech................................... 5
_____ Dutch................................... 6
_____ English................................. 7
_____ Finnish................................. 8
_____ French.................................. 9
_____ Gaelic.................................. 10
_____ German.................................. 11
_____ Hungarian............................... 12
_____ Italian................................. 13
_____ Japanese................................ 14
_____ Korean.................................. 15
_____ Lithuanian.............................. 16
_____ Norwegian............................... 17
_____ Persian................................. 18
_____ Philippine languages.................... 19
_____ Polish.................................. 20
_____ Portuguese.............................. 21
_____ Rumanian................................ 22
_____ Russian................................. 23
_____ Serbo-Croatian.......................... 24
_____ Slovak.................................. 25
_____ Spanish................................. 26
_____ Swedish................................. 27
_____ Thai.................................... 28
_____ Ukrainian............................... 29
_____ Vietnamese.............................. 30
_____ Yiddish................................. 31
_____ Other (specify) _______________......... 32

CH15

Thank you very much for your time. Please use the back of the cover page to write any additional comments.

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APPENDIX C

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March 21, 1995

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DATE PAID 3/27/95
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R. BOB SMITH III

Joanne Levine
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Apt. 25A
New York, NY 10016

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Joanne Levine
March 21, 1995
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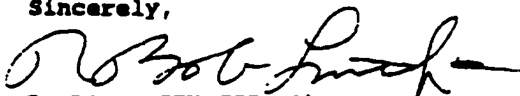

R. BOB SMITH III, Ph.D.
President

RBS/bv

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BY: ____________________
JOANNE LEVINE

DATE: 3/24/95

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BY: ____________________
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DATE: 3-27-95

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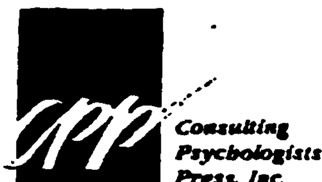

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THE CITY UNIVERSITY OF NEW YORK

CUNY DRC
Committee
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Project Administrator
Karen D. Gerber
Administrative Assistant

CUNY DRC
at John Jay College of
Criminal Justice
Room 2111
New York, New York 10019

June 9, 1995

Ms. Joanne Levine C.S.W., M.P.H.
200 East 33rd. Street #25A
New York, New York 10016

Dear Ms. Levine:

The City University of New York Dispute Resolution Consortium [CUNY DRC] Committee is pleased to inform you that your proposal for a 1995-96 CUNY DRC Research Mini-Grant has been approved for $1,500 to support the project described in your application. Funding for this project is made possible by the William and Flora Hewlett Foundation and the City University of New York Office of Academic Affairs.

The following terms apply to your use of the CUNY DRC grant funds:

[1] A countersigned copy of this letter must be received by the CUNY DRC before payments are made.

[2] These grant funds will be used for such purposes directly in accordance with the approved budget. It is also understood that no substantial variances will be made from the approved budget without the CUNY DRC Committee's prior approval in writing. Any grant funds not expended or committed for the purposes of the grant will be returned to the CUNY DRC.

[3] A 3 page written Interim Report describing the progress of your research in writing is to be furnished to the CUNY DRC to the attention of Karen Gerber, Project Administrator, no later than December 10, 1995. In addition, the 10 page Final Report which includes a financial report of all grant expenditures and a narrative report of your project must be submitted to the CUNY DRC no later than June 10, 1996.

Funded by the William and Flora Hewlett Foundation and The City University of New York

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[4] Two copies of any publications produced or disseminated wholly or in part with these funds will be furnished to the CUNY DRC. Such publications should include an appropriate acknowledgement of the support from the City University of New York Dispute Resolution Consortium and the William and Flora Hewlett Foundation.

[5] The CUNY DRC will include information on this grant in its periodic public reports and may also refer to the grant in press releases.

[6] All funded proposals become the property of the CUNY DRC. They may be shared with others as deemed necessary.

[7] **Special conditions for your grant:**
Requested paperwork for any special conditions regarding your proposal must be submitted to the CUNY DRC before your funds will be released. All those that apply are checked.

_x_ Obtain Internal Review Board approval from your home college and submit IRB's written statement to CUNY DRC.

__ Obtain written consent of research subjects and submit to CUNY DRC.

__ Obtain consent of legal guardians for research subjects under the age of 18.

_x_ Revise Budget:

_x_ A) Provide justification for the following grant expenditure(s):

_x_ 1. Printing (10¢ per page for large order seems high).
_x_ 2. Mailing (Amount allocated for baseline and two follow-up mailings seems insufficient).
_x_ 3. Cost for computer time (investigate using CUNY Computer facilities at no charge to students).

__ B) Include 12% for fringe benefits in salary for supervised staff.

__ Modify project product

__ Other: ______________________________

[8] Extensions will not be granted on the use of grant funds or on grant report deadlines unless extreme and unforeseen circumstances prohibit grant recipients(s) from completing the project within the designated time period.

[9] Grant Recipients will be expected to participate in occasional research round tables, to discuss their current research with CUNY faculty, staff and students.

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Distribution of funds:

The Research Foundation and CUNY will pay your approved grant expenses including payment of your project personnel when **proper supporting documents and original receipts** are submitted, as follows:

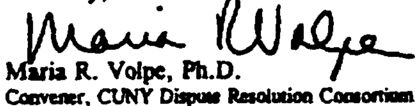
[a] the first $750 of billable expenses will be paid as expenses are incurred;

[b] the remaining $750 of billable expenses will be paid upon submission to the CUNY DRC of the 10 page Final Report [including a financial report of all grant expenditures and a narrative report of your project] which must be submitted no later than June 10, 1996.

Forms from the Research Foundation and the City University of New York will be used to process receipts. They are available from Karen Gerber and Betsy Morales at the CUNY DRC.

Please sign and return the enclosed copy of this letter indicating acceptance of the terms of the grant by June 30, 1995. Should you have any questions, please feel free to contact Karen Gerber at 212-237-8692. We look forward to working with you during the coming year and extend every good wish for the success of this endeavor.

Sincerely,



Maria R. Volpe, Ph.D.
Convener, CUNY Dispute Resolution Consortium

I hereby accept and agree to the terms of the grant as set forth above.

[Name of Grantee(s)]

[Name of Grantee(s)]

[Signature]

[Signature]

Date 6/15/95

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City University of New York Dispute Resolution Consortium (CUNY DRC)
1995-96 RESEARCH MINI-GRANT RECIPIENTS

Jill Bellinson, John Jay College of Criminal Justice, Children's Center
Application of Conflict Management Principles to Sibling Rivalry in Children

Mary Sue Donsky, New York City Technical College, Legal Assistant Studies
An Investigation of Legal Disputes Between Unmarried Cohabitants

Beth Spenciner Rosenthal, York College, Social Sciences
Reducing Interpersonal Conflict Among Inner-City Youth

Nancy Ziehler, Maria Grace La Russo, and Dominick Carielli. Queens College
Calandra Italian American Institute
Italian American Students at CUNY: An Exploratory Study of Interpersonal Conflict and Student Development

Joanne Levine, Graduate School and University Center Doctoral Student, Social Work
Conflicted Helping: The Mediator Role in Discharge Planning and It's Relationship to Job Satisfaction and Burnout in Health Care Social Workers

at John Jay College. Rm. 2111. 445 W. 59th St., NY, NY 10019: Phone: 212/237-8692: Fax: 212/237-8742

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BIBLIOGRAPHY

Abramson, J. (1988). Participation of elderly patients in discharge planning: Is self determination a reality? Social Work, 33(5), 443-448.

Abramson, J. (1990). Enhancing patient participation: Clinical strategies in the discharge planning process. Social Work in Health Care, 14(4), 53-71.

Abramson, M. (1990). Ethics and technological advances: Contributions of social work practice. Social Work in Health Care. 15(2), 5-17.

Abramson, M., & Black, R. (1985). Extending the boundaries of life: Implications for practice. Health and Social Work, 10(3), 165-173.

Abramson, J., Donnelly, J., King, M., & Mailick, M. (1993). Disagreements in discharge planning: A normative phenomenon. Health and Social Work, 18(1), 57-64.

Abramson, J. (1985). Disagreement among principals in the discharge planning process. Discharge Planning Update, 6(1), 4-10.

Adams, J.S. (1976). The structure and dynamics of behavior in organizational boundary roles. In M. Dunnette (Ed.), Handbook of Industrial and Organizational Psychology, Chicago: Rand McNally.

American Hospital Association. (1994). Guide to the Health Care Field. Chicago, IL.

Barrett, G. & Bass, B.C. (1976). Cross-cultural issues in industrial and organizational psychology. In M. Dunnette (Ed.), Handbook of Industrial and Organizational Psychology, Chicago: Rand McNally.

Bazerman, M., Mannix, E., & Thompson, L. (1988). Negotiations in small groups. National Institute for Dispute Resolutions, 1-35.

Bazerman, M., Mannix, E., & Thompson, L. (1988). Groups as mixed-motive negotiations. National Institute for Dispute Resolution, 1-41.

Berger, C., Cayner J., Jensen, G., Mizrahi, T., Scesny, A. & Tractenberg, J.(1996). The Changing Scene of Social Work in Hospitals. Health & Social Work 21 (3) 161 - 240.

Berkman, B., Bonander, E., Kemler, B., Rubinger, M., Rutchick, I. & Silverman, P.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

(1996). Social Work in the Academic Medical Center: Advanced Training - A Necessity. In M. Mailick & P. Caroff (Eds.) Professional Social Work Education and Health Care: Challenges for the Future. Binghamton, NY: The Haworth Press

Berkman, B. (1980). Psychosocial problems and outcome: An external validity study. Health and Social Work, 5-21.

Berkman, B. (1990). The bio-medical environment and its challenge for social work research. Social Work in Health Care. 15(1), 3-8.

Berryman - Fine, C. & Brunner, C. (1987). The Effects of Sex of Source of Target of Interpersonal Conflict Management Styles. The Southern Speech Communications Journal 53, 38 -48.

Bison, H. (1988). Managing Conflict. Newbury Park, Ca: Sage.

Boulding, K. (1962). Conflict and Defense: A General Theory. New York: Harper Torchbooks.

Bourque, L. & Fielder, E. (1995). How to Conduct Self Administered and Mail Surveys, Thousand Oaks, CA: Sage Publications.

Brown, J.S., & Furstenberg, A. (1993). Restoring control: Empowering older patients and their families during health crisis. Social Work and Health Care, 1-28.

Cannon, M.A. (1954). The use of medical social work. In D. Goldstine (Ed.), Readings in Theory and Practice of Medical Social Work, Chicago: University of Chicago Press.

Caputi, M. (1982). A "quality of life" model for social work practice in health care. Health and Social Work, 7(2), 103-110.

Carbine, M. (1991). Adapting dispute resolution techniques to the health care field. Forum, 15-17.

Chapin, B. (1987, September-October). Autonomy and paternalism: Horns of a dilemma. Discharge Planning Update, 23-24.

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

Chetkow-Yanoov, B. (1991). Teaching conflict resolution at schools of social work: A proposal. International Social Work, 57-68.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Christ, G.H.. (1996). School and Agency Collaboration in a Cost Conscious Health Care Environment. In M. Mailick & P. Caroff (Eds.), Professional Social Work Education and Health Care: Challenges for the Future. Binghamton, NY: The Haworth Press.

Cloke, K. (1994). Mediation: Revenge and the Magic of Forgiveness. Santa Clara, CA: Center for Dispute Resolution.

Conlon, D. (1988). Mediator behavior and interest: Effects on mediator and disputant perceptions. National Institute for Dispute Resolution, 1-85.

Cooper, C., & Marshall, J. (1978). Sources of manager and white collar stress. In C. Cooper & R. Payne (Eds.), Stress at Work, John Wiley & Sons, Inc.

Cornelius, D. (1994). Managed care and social work: Constructing a context and a response. Social Work in Health Care, 20(1), 47-63.

Cornwall, J. (1994). The road to empowerment in mental health organizations: Speed bumps, detours and road blocks. Administration and Policy in Mental Health, 22(1), 19-25.

Coulton, C. (1990). Research in patient and family decision making regarding life sustaining and long term care. Social Work in Health Care 15(1), 63-78.

Coulton, C., Dunkle, R., Chow, J., Haug, M., & Vielhaber, D. (1988). Dimensions of post-hospital care decision-making: A factor analytic study. The Gerontological Society of America, 218-223.

Coulton, C., Dunkle, R., Goode, R., & Mackintosh, J. (1982). Discharge planning and decision making. Health Care and Social Work, 7(4), 253-261.

Coulton, C., Dunkle, R., Chow, J., Haug, M., & Vielhaber, D. (1989). Locus of control and decision making for post-hospital care. The Gerontological Society of America, 29(5), 627-632.

Cowles, L.A., & Lefcowitz, M. (1992). Interdisciplinary expectations of the medical social worker in the hospital setting. Health & Social Work, 17(1), 57-65.

Cowles, L. & Lefcowitz, M. (1995). Interdisciplinary Expectations of the Medical Social Worker in the Hospital Setting: Part 2. Health & Social Work, 20 (4), 279 - 286.

Cox, E., & Parsons, R. (1992). Senior-to-senior mediation service project. Gerontologist, 32(3), 420-422.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Craft, J. (1990) Statistics and Data Analysis for Social Workers. Illinois: Peacock Publishers.

Cuzzi, L., Holden, G., Grob, G. & Bazer, C. (1993). Decision making in social work: A review. Social Work in Health Care, 18(2), 1-22.

Dane, B., & Simon, B. (1991). Resident guests: Social workers in host settings. Social Work, 36(3), 208-213.

Davidson, K.W. (1990). Role blurring and the hospital social worker's search for a clear domain. Health & Social Work, 15(3), 228-234.

Davidson, K.W. (1978). Evolving social work roles in health care: The case of discharge planning. Social Work in Health Care, 4(1), 43-54.

Dillon, C. (1990). Managing stress in health social work today. Social Work in Health Care, 14(4), 91-108.

Dockter, B., Black, D.R., Hovell, M.F., Engleberg, D., Amick, T., Neimer, D., & Sheets, N. (1988). Families and intensive care nurses: Comparisons of perceptions. Patient Education and Counseling, 29-36.

Doelker, R., & Lynett, P. (1982). A needs assessment model for staff development in multiprogram human service agencies. Journal of Continuing Social Work Education, 2(1), 14-37.

Doelker, R., & Lynett, P. (1983). Strategies in staff development: An ecological approach. Social Work, 28, 380-384.

Donnelly, J. & King, M. (December, 1990). Extent and type of disagreement about discharge planning. The Society Page. Metropolitan New York Chapter, Society for Social Work Directors.

Donnelly, P. (1992). The impact of culture on psychotherapy: Korean clients' expectations in psychotherapy. Journal of the New York State Nurses Association, 23(2), 12-15.

Donnelly, J. (1993, April/May). Disagreements in discharge planning - Phase 2 Report. The Society Page. Society for Social Work Administrators in Health Care, 1-3.

Donnelly, J. (1992). A frame for defining social work in a hospital setting. Social Work in Health Care, 18(1), 107-119.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Drew, L., Biordi, D., & Gillies, D. (1988). How discharge planners and home health nurses view their patients. Nursing Management, 19(4), 66-70.

Dubler, N.N., & Marcus, L.J. (1994). Mediating Bioethical Disputes: A Practical Guide. United Hospital Fund of New York.

Dubler, N. (1990). Autonomy and accommodation: Mediating individual choice in the home setting. Generations, (Suppl.), 29-31.

Dunst, C., Trivette, C., & LaPointe, N. (1994). Meaning and key characteristics of empowerment. In C. Durst, C. Trivette & A. Deal (Eds.). Supporting & Strengthening Families: Vol. 1. Methods, Strategies and Practices (pp. 12-28). Cambridge, MA: Brookline Books.

Dworkin, J., Jacob, L., & Scott, E. (1990). The boundaries between mediation and therapy: Ethical dilemmas. Mediation Quarterly, 107-119.

Eagan, M., & Kadushin, G. (1995). Competitive allies: Rural nurses' and social workers' perceptions of the social work role in the hospital setting. Social Work in Health Care, 20(3), 1-23.

Elkin, M. (1985). Defining the interprofessional boundaries between the law and the behavioral sciences in the practice of divorce mediation. Conciliation Courts Review, v-vii.

Elso, A.L. (1994). Assessment of mental stress factors at work. In. B. Dickerson & E. Horvath (Eds.), Occupational Medicine (pp. 945-1237). St. Louis: Mosby.

Epstein, L. (1978). Short term treatment in health settings: Issues, concepts, dilemmas. Social Work in Health Care, 4(1), 77-98.

Faherty, V. (1979). Continuing social work education: Results of a Delphi survey. Journal of Education for Social Work, 15(1), 12-19.

Fandetti, D., & Goldmeier, J. (1988). Social workers as cultural mediators in health care settings. National Association of Social Workers, 13(3), 171-179.

Fargo, J. (1986). Academic programs in family mediation: Some thoughts from a family life educator. Key Issues in Family Mediation Training and Practice, 3-20.

Fein, E. (1995, March 18). Hospitals say cuts in Medicaid will mean longer stays. The New York Times, pp. 1, 28.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Fisher, S., & Groce, S. (1985). Doctor-patient negotiation of cultural assumptions. Sociology of Health and Illness, 7(3), 342-374.

Fisher, F., Ury., W. & Patton, B. (1981) Getting to Yes . New York: Penguin Group

Fisher, R. (1995). Political social work. Journal of Social Work Education, 31 (2) 194 - 203.

Fisher, R. & Karger, H.J. (1997). Social Work And Community In A Private World. White Plains, NY: Longman

Folberg, J., & Taylor, A. (1984). Mediation. San Francisco: Jossey-Bass.

Foster, Z., & Brown, D. (1978). The social work role in hospital discharge planning: An administrative history. Social Work in Health Care, 4(1), 55-63.

Frankenlaenser, M. (1976). Underload and overload in working life: Outline of a multidisciplinary approach. Journal of Human Stress, 2(3), 35-46.

Frans, D. (1993). A scale for measuring social worker empowerment. Research on Social Work Practice, 3(3), 312-328.

Freeman, E. (1992). Who is better prepared to fill the role of case manager? Nurses or social workers? Journal of the Association of Nurses in AIDS Care, 3(2), 36-7.

Garber, L., Brenner, S., & Litwin, D. (1986). A survey of patient and family satisfaction with social work services. Social Work in Health Care, 11(3), 13-23.

Germain, C. (1977). An ecological perspective on social work practice in health care. Social Work in Health Care, 3(1), 51-62.

Germain, C., & Gitterman, A. (1980). The Life Model of Social Work Practice. New York: Columbia University Press.

Gibson, J.M., & West, M.B. (1991). Hospital ethics committee: Mediation and case review. Forum, 22-23.

Globerman, J., Davis, J. & Walsh, S. (1996). Social Work in Restructuring Hospitals: Meeting the Challenge. Health & Social Work 21 (3) 178 - 188.

Gold, L. (1985). Reflections on the transition from therapist to mediator. Legal and Family Perspectives in Divorce Mediation, 15-26.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Goldstine, D. (1954). The literature of medical social work: Review and evaluation. In D. Goldstine (Ed.), Readings in the Theory and Practice of Medical Social work, Chicago: University of Chicago Press.

Goode, W.C. (1960). A theory of role strain. American Sociological Review, 25(4), 483-496.

Gould, K. (1987). Life model versus conflict model: A feminist perspective. Social Work, 32, 346-351.

Greenhalgh, L. (1987). SMR Forum: Managing conflict. Sloan Management Review.

Guilford, J. P. & Frucher, B. (1973). Fundamental Statistics in Psychology and Education New York: McGraw Hill.

Gutierrez, L. (1994). Beyond coping: An empowerment perspective on stressful life events. Journal of Sociology and Social Welfare, 21(3), 201-219.

Guy, M.E. (1986). Interdisciplinary conflict and organizational complexity. Hospital and Health Services, 111-121.

Harrison, W.D. (1980). Role Strain and Burnout in Child Protective Service Workers. Administration in Social Work, 3, 207 - 217.

Hepworth, D.H., Rooney, R.H. & Larsen, J. (1997). Direct Social Work Practice, 5th Ed. Pacific Grove, CA: Brooks/Cole Publishing Company

Higgins, N.C. (1986). Occupational stress and working women: The effectiveness of two stress-reduction programs. Journal of Vocational Behavior, 29, 66-78.

Hocker, J. & Wilmont, W. (1995). Interpersonal Conflict. Iowa: Brown and Benchmark.

Hoppe, S. (1990). Work stressors: Role strain, inter-role conflict, and role loss. In C. Bonjean and D. Foss (Eds.), Mental Health Research in Texas: Retrospect and Prospect, Hogg Foundation for Mental Health: Austin, TX.

Hull, J. G., Van Treuren, R. R., & Virnelli, S. (1987). Hardiness and health: A critique and alternative approach. Journal of Personality and Social Psychology, 53(3), 518-530.

Iglehart, A.P. (1990). Discharge planning: Professional perspectives versus organizational effects. Health and Social Work, 15(4), 301-309.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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

Kadushin, G. & Kulys, R. (1993). Discharge Planning Revisited: What do social workers actually do? Social Work 38 (6) 713 - 726.

Kadushin, G., & Kulys, R. (1995). Job satisfaction among social work discharge planners. Health and Social Work, 20(3), 174-184.

Kahn, R., Wolfe, R., & Snoek, J.D. (1964). Organizational Stress: Studies in Role Conflict and Ambiguity. New York: John Wiley & Sons, Inc.

Kalimo, R., & Mejman, T. (1978). Psychological and behavioral responses to stress at work. In C. Cooper & R. Payne (Eds.), Stress at Work, John Wiley & Sons, Inc.

Kane, R.L., Bell, R.M., & Riegler, S.Z. (1986). Value preference for nursing home outcomes. The Gerontological Society of America, 26(3), 303-308.

Karger, H.J. & Stoesz, D. (1998). American Social Welfare Policy: A Pluralist Approach, 3rd Ed. White Plains, NY: Longman (in press)

Keating, M.J., Jr. (1985). Public ends and private means: Accountability among private providers of public social services. National Institute for Dispute Resolution.

Keenan, E., & Pinkerton, J. (1991). Some aspects of empowerment: A case study of work with disadvantaged youth. Social Work with Groups, 14(3-4), 109-124.

Kerson, T.S. (1979). Sixty years ago: Hospital social work, 1918. Social Work in Health Care, 4(3), 331-343.

Kestner, P., & Wood, E.F. (1988). Mediation: The coming of age - A mediator's guide in serving the elderly. American Bar Association Standing Committee on Dispute Resolution and Commission of Legal Problems of the Elderly for the National Institute for Dispute Resolution.

Knight, V., Saunders, D.M., & Sheppard, B.H. (1987). When do employees speak up? Factors influencing the propensity to use voice. National Institute for Dispute Resolution.

Knox, A. (1981). Proficiencies needed to administer continuing social work education. Journal of Continuing Social Work Education, 1, 3-21.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Kobasa-Oulette, S. C., & Pulletti, M. (1983). Personality and social resources in stress resistance. Journal of Personality and Social Psychology, 45(4), 839-850.

Koeske, G., Kirk, S., Koeske, R. & Rauktis, M. (1994). Measuring the Monday Blues: Validation of a job satisfaction scale for the human services. Social Work Research, 18 (1), 27 - 35.

Kolb, D., & Rubin, J.Z. (1989). Research into mediation: What we now know what's left to learn. Dispute Resolution Forum, 1-22.

Kolb, D. (1985). To be a mediator: Expressive tactics in mediation. In K. Kressel & D.G. Pruitt (Eds.), The Mediation of Social Conflict, New York: Plenum.

Kolb, D. (1989). Her place at the table: A curriculum module on gender and negotiation. National Institute for Dispute Resolution.

Krause, N., & Markides, K.S. (1985). Employment and psychological well-being in Mexican-American women. Journal of Health and Social Behavior, 26, 15-26.

Kressel, K., & Pruitt, D. (1989). Mediation Research. San Francisco: Jossey-Bass.

Kressel, K., & Pruitt, D. (1989). A research perspective on the mediation of social conflict. In The Process and Effectiveness of Third-Party Intervention, San Francisco: Jossey-Bass.

Kressel, K., & Pruitt, D. (1985). Themes in the mediation of social conflict. The Society for the Psychological Study of Social Issues, 179-199.

Kulys, R., & Meyer, R. (1985). Good health: Whose responsibility? Social Work in Health Care, 63-84.

Kulys, R., & Davis, M.A. (1987). Nurses and social workers: Rivals in the provision of social services? Health & Social Work, 12, 101-112.

Kumar, R. (1987). Affect, cognition, and decision making in negotiations: A conceptual integration. National Institute for Dispute Resolution, 1-26.

Kurzman, P. A. (1976). Private practice as a social work function. Social Work, 21(5), 363-368.

Lackoff, R. (1975). Language and Women's Place. New York: Harper & Row.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Link, B., Mesango, F., Lubner, M., & Dohrenwend, B. (1990). Problems in measuring role strains and social functioning in relation to psychological symptoms. Journal of Health and Social Behavior, 31, 354-369.

Lister, L. (1980). Role expectations of social workers and other health care professionals. Health & Social Work, 5, 41-49.

Locke, E. (1976). The nature and causes of job satisfaction. In M. Dunnette (Ed.), Handbook of Industrial and Organizational Psychology, Chicago: Rand McNally.

Lurie, A. (1982). The social work advocacy role in discharge planning. Social Work in Health Care, 8(2), 75-85.

MacCrimmon, K., & Taylor, R. (1976). Decision making and problem solving. In M. Dunnette (Ed.), Handbook of Industrial and Organizational Psychology, Chicago: Rand McNally.

Mahler, B. (1988, July-August). Discharge planning: Continuity of Rehabilitation. Discharge Planning Update, 3-4.

Mann, L., & Janis, I. (1982). Conflict theory of decision making and the expectancy-value approach. In N. Feather (Ed.), Expectations and Actions: Expectancy-Value Models in Psychology, New Jersey:; Lawrence Erlbaum.

Marcus, L.J., Dorn, B., Kritek, P.B., Miller, V.G. & Wyatt, J.B. (1995). Renegotiating Health Care. San Francisco, CA: Jossey - Bass Publishers.

Marriott, A., Sexton, L., & Stanley, D. (1994). Components of job satisfaction in psychiatric social workers. Health and Social Work, 19(3), 199-205.

Maslach, C., & Jackson, S. (1981). The measurement of experienced burnout. Journal of Occupational Behavior, 2, 99-113.

Maslach, C., & Jackson, S. (1986). Maslach Burnout Inventory Manual. Consulting Psychologists Press: Palo Alto, CA.

McGrath, J. (1976). Stress and behavior in organizations. In M. Dunnette (Ed.), Handbook of Industrial and Organizational Psychology, Chicago: Rand McNally.

Menaghan, E. (1983). Individual coping efforts: Moderators of the relationship between life stress and mental health outcomes. In H. Kaplan, Psychosocial Stress: Trends in Theory and Research, Orlando: Academic Press.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Miller, J. (1991). Women's and Men's Scripts for Interpersonal Conflict. Psychology of Women Quarterly 15 ,15 -29.

Mizrahi, T. (1993). Managed care and managed competition: A primer for social work. Health and Social Work, 18(2), 86-90.

Moore, C.W. (1986). The Mediation Process. San Francisco: Jossey-Bass.

Morrow-Howell, N., Proctor, E.K., & Mui, A.C. (1991). Adequacy of discharge plans for elderly patients. Social Work Research and Abstracts, 27(1), 6-13.

Mui, A. (1992). Caregiver strain among black and white daughter caregivers: A role theory perspective. The Gerontologist, 32(2), 203-221.

Murdach, A. (1995). Decision-making situations in health care. Health & Social Work, 20(3), 187-190.

Noller, P. (1992). Gender and Emotional Communication in Marriage: Different Cultures or Different Social Power? Journal of Language and Social Psychology, 2 (½), 132 - 152.

Osipow, S., & Spokane, A. (1992). Occupational Stress Inventory Manual (Research version). Psychological Assessment Resources, Inc.: Odessa, FL.

Parsons, R., & Cox, E.O. (1989). Family mediation in elder caregiving decisions: An empowerment intervention. National Association of Social Workers, 122-126.

Parsons, R.J. (1992). The mediator function in generalist practice: Enhancing community in client systems. In Social Work Values in Action. 1992 Annual Program Meeting of CSWE Revisioning Community, Kansas City, KS.

Parsons, R.J. (1991). The mediator role in social work practice. Social Work, 36(6), 483-487.

Parsons, R.J. (1991). Empowerment: Purpose and practice principle in social work. Social Work with Groups, 14(2), 7-21.

Parsons, R., Jorginsen, J., & Hernandez, S. (1993). The Integration of Social Work Practice. Monterey, CA: Brooks/Cole.

Peachey, D. (1989). What people want from mediation. In K. Kressel & D. Pruitt (Eds.), The Process and Effectiveness of Third-Party Intervention, San Francisco: Jossey-Bass.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Pearlin, L. (1983). Psychosocial stress: Trends in theory and research. In H. Kaplan, (Ed.), Psychosocial Stress: Trends in Theory and Research, Orlando: Academic Press.

Pearlin, L. (1989). The sociological study of stress. Journal of Health and Social Behavior, 30, 241-256.

Perloff, J., (1996). Medicaid Managed Care and the Urban Poor: Implications for Social Work. Health and Social Work, 21 (3), 189 - 195

Pinderhughes, E.B. (1983). Empowerment for our clients and for ourselves. Social Casework: The Journal of Contemporary Social Work, 29, 331-338.

Pines, A., Aronson, E., & Kafry, D. (1981). Burnout: From Tedium to Personal Growth. New York: Free Press.

Pines, A., & Kafry, D. (1978). Occupational tedium in the social services. Social Work, 23(6), 499-507.

Potter, B. (1987). Preventing Job Burnout. Palo Alto: Consulting Psychologist Press.

Proctor, E., Morrow-Howell, N., Albaz, R., & Wein, C. (1992). Patient and family satisfaction with DC plans. Medical Care, 30(3), 262-275.

Pruitt, D.G. & Kressel, K. (1985). The mediation of social conflict: An introduction. In K. Kressel & D.G. Pruitt (Eds.), The Mediation of Social Conflict, New York: Plenum.

Rahim, A. (1983). Rahim Organizational Conflict Inventories: Professional Manual. Consulting Psychologists Press: Palo Alto, CA.

Rahim, A., and Bonoma, T. (1979). Managing organizational conflict: A model for diagnosis and intervention. Psychological Reports, 44, 1323-1344.

Rappaport, J. (1994). Empowerment as a guide to doing research: Diversity as a positive value. In E.J. Trickett, R.J. Watts, & D. Birman (Eds.), Human Diversity: Perspectives on People in Context (pp. 359-382). San Francisco, CA: Jossey-Bass Publishers.

Ratliff, N. (1988). Stress and burnout in the helping professional social casework. The Journal of Contemporary Social Work, 69(3), 147-154.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Regehr, C. (1994). The use of empowerment in child custody mediation: A feminist critique. Mediation Quarterly, 11(4), 361-371.

Richardson, M.S. (1994). Agency/empowerment in clinical practice. Journal of Theoretical and Philosophical Psychology, 14(1), 40-49.

Roberts, C. (1989). Conflicting professional values in social work and medicine. Health and Social Work, 211-218.

Roberts, R.E., & Roberts, C.R. (1982). Marriage, work, and depressive symptoms among Mexican-Americans. Journal of Behavioral Sciences, 4, 199-221.

Roehl, J., & Cook, R. (1989). Mediation in interpersonal disputes: Effectiveness and limitations. In K. Kressel & D. Pruitt (Eds.), Mediation Research: The Process and Effectiveness of Third-Party Intervention, San Francisco: Jossey-Bass.

Roehl, J., & Cook, R. (1985). Issues in Mediation: Rhetoric and reality revisited. In K. Kressel & D.G. Pruitt (Eds.), The Mediation of Social Conflict, New York: Plenum.

Rosenfield, S. (1989). The effects of women's employment: Personal control and sex differences in mental health. Journal of Health and Science Behavior, 30, 77-91.

Ross, L.E., Mirowsky, J., & Ulbrich, P. (1983). Distress and the traditional female role: A comparison of Mexicans and Anglos. American Journal of Sociology, 89, 670-682.

Rothman, R. (1979). Occupational roles: Power and negotiation in the division of labor. The Sociological Quarterly, 20, 495-515.

Saenz, R., Goudy, W.J., & Lorenz, F. (1989). The effects of employment and depression among Mexican-American women. Journal of Marriage and the Family, 51, 239-251.

Sandowski, C. (1985). The role of the discharge planner. Rehabilitation Literature, 46(1 & 2), 16-20.

Sawatzky, D.D., Jeune, R.E., & Clark, G.T. (1994). Becoming Empowered: A study of counselor development. Canadian Journal of Counseling, 28(3), 177-192.

Schinke, S.P., Smith, T.E., Gilchrist, L.D., & Wong, S.E. (1981). Measuring the impact of continuing education. Journal of Education for Social Work, 17(1), 59-64.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Severson, M., & Bankston, T. (1995). Social work and the pursuit of justice through mediation. Social Work, 40(5), 683-691.

Shapiro, D., Drighe, R., & Bret, J. (1985). Mediator behavior and the outcome of mediation. In K. Kressel & D.G. Pruitt (Eds.), The Mediation of Social Conflict, New York: Plenum.

Shaw, L. & McMahon, B. (1990). Family-staff conflict in the rehabilitation setting: Causes, consequences, and implications. Brain Injury, 4(1), 87-93.

Sherman, W.R., & Wenocur, S. (1983). Empowering public welfare workers through mutual support. Social Work, 28, 375-37.

Siefert, K., Jayaratne, S.T., & Chess, W. (1991). Job satisfaction, burnout, and turnover in health care social workers. Health and Social Work, 16(3), 193-202.

Simkins-Bullock, J. & Wilman, B. (1991). An Investigation in the Relationships between Gender and Language. Sex Roles 24 (3/4) 149 - 160.

Smith, M. (1990). Program Evaluation in the Human Services. New York: Springer.

Snock, D.J. (1966). Role strain in diversified role sets. The American Journal of Sociology, 71(4), 363-372.

Soderfeldt, M., Soderfeldt, B., & Wang, L.E. (1995). Burnout in social work. Social Work, 40(5), 638-646.

Solomon, B.B. (1976). Black Empowerment: Social Work in Oppressed Communities. New York: Columbia University Press.

Spitzer, W.J. & Nash, K.B. (1996). Educational Preparation for Contemporary Health Care Social Work Practice. In M. Mailick & P. Caroff (Eds.), Professional Social Work Education and Health Care: Challenges for the Future, Binghamton, NY: The Haworth Press.

Sullivan, L.W. (1991). Critical issues facing health care reform. Forum, 1-3.

Thoits, P. (1983). Dimensions of life events that influence psychological distress: An evaluation and synthesis of the literature. In H. Kaplan (Ed.), Psychosocial Stress: Trends in Theory and Research, Orlando: Academic Press.

Thomas, K. (1976). Conflict and conflict management. In M. Dunnette (Ed.), Handbook of Industrial and Organizational Psychology, Chicago: Rand McNally.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Thompson, L., & Hastie, R. (1988). Influence on negotiators' perceptions of the task and the opponent on negotiation outcomes. National Institute for Dispute Resolution.

Turner, J.R. (1983). Direct, indirect, and moderating effects of social support on psychological distress and associated conditions. In H. Kaplan (Ed.), Psychosocial Stress: Trends in Theory and Research, Orlando: Academic Press.

Van Harrison, R. (1978). Person-environment fit and job stress. In C. Cooper & R. Payne (Eds.), Stress at Work, John Wiley & Sons, Inc.

Volland, P. (1996). Social Work Practice in Health Care: Looking to the future with a different lens. In M. Mailick & P. Caroff (Eds.), Professional Social Work Education and Health Care: Challenges for the Future, Binghamton, NY: The Haworth Press.

Wall, J. (1981). Mediation: An analysis, review, and proposed research. Journal of Conflict Resolution, 25, 157-180.

Warfel, K. (1984). Gender Schemas and the Perception of Speech Style. Communication Monographs 51, 253 - 267.

Weiss, S.E., & Goldstein, S.B. (1987). Culture's consequence in dispute resolution. Dispute Resolution Forum.

White, J.H. (1985). Developing an instrument to measure satisfaction with divorce mediation. Mediation Quarterly, 10, 91-98.

Whiting, R.A. (1982 & 1985). The use of mediation as a dispute settlement tool: An historical review and scientific examination of the role and process of mediation. National Institute for Dispute Resolution.

Williams, N.C. (1988). Role making among married Mexican-American women: Issues of class and ethnicity. Journal of Applied Behavioral Sciences, 24, 203-217.

Wright, R., King, S.W., & Berg, W.E. (1985). Job satisfaction in the workplace: A study of black females in management positions. Journal of Social Service Research, 8, 65-79.

Wright, R., King, S.W., & Berg, W.E. (1985). Job satisfaction among black female managers: A causal approach. Human Relations, 40, 489-506.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Zabora, J., Fetting, J., Shanley, V., Seddon, C., & Enterline, J. (1989). Predicting conflict with staff among families of cancer patients during prolonged hospitalization. Journal of Psychosocial Oncology, 7(3), 103-111.

Zautra, A., & Guarnacci, C. (1986). Measuring small life events. American Journal of Community Psychology, 14(6), 629-655.

Zautra, A., Eblen, C., & Reynolds, K. (1986). Job stress and task interest: Two factors in work life quality. American Journal of Community Psychology, 14(4), 377-393.

Zautra, A., Reynolds, K., & Eblen, C. (1987). Some determinants of employee turnover in a psychiatric facility. Administration in Mental Health, 15(1), 11-17.

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