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DEVELOPMENT OF A SUPPORT PROGRAM FOR SOCIAL WORKERS
SERVING CANCER PATIENTS

City University of New York

D.S.W. 1983

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DEVELOPMENT OF A SUPPORT PROGRAM FOR SOCIAL
WORKERS SERVING CANCER PATIENTS

by

Kay W. Davidson

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

1983

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1983

This manuscript has been read and accepted for the Graduate Faculty in Social Work in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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1983

Abstract

DEVELOPMENT OF A SUPPORT PROGRAM FOR SOCIAL
WORKERS SERVING CANCER PATIENTS

by

Kay W. Davidson

Adviser: Dr. Irwin Epstein

This exploratory study was undertaken to determine whether a program of support would help social workers in general hospitals cope better with stresses which they experience in working with cancer patients. The need for special programs was assessed and a model program was designed and implemented.

A study of relevant research and a needs assessment survey supported the proposition that social workers serving cancer patients experience both stresses and satisfactions and that a structured program of support would enable workers to cope more effectively with stresses.

The program was implemented during 1981 at a large, voluntary, teaching hospital with an established social work department. The sample group, restricted to workers with Master's degrees, was composed of ten self-

selected workers, including two whose work combined direct practice and staff supervision and four who were their supervisees.

The program consisted of nine group meetings of one and a half hours each with the investigator as leader. After the program, the support group was continued without a leader.

A formative evaluation of the project indicated that the goal of developing a model program for peer support and mutual aid was substantially achieved. A unique component of the support offered by peers was the personal disclosure and sharing which narrowed the distance between all members, including supervisors, and promoted mutual aid.

Assessment of the program's effects on participants indicated that feelings of competence were strengthened and that sensitivity and awareness of the complexity of their work, its stresses and workers' feelings were developed.

Findings of the study suggest that hospital social work departments should consider the development of programs for staff support in relation to cancer and that even departments with highly competent supervision should consider and test the value of peer groups for staff support.

This project delineated the significant stresses experienced by social workers who work with cancer patients in general hospitals, specified coping patterns used by such workers, and developed a peer support and mutual aid program that helped the workers to modify their ways of coping with highly problematic aspects of their work.

This work is dedicated
in loving memory of my father,
Sonny (Hyman) Wallis,
who would have been very proud.

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I want to thank the members of my project committee for their help and guidance. Dr. Irwin Epstein, as my Chairperson and advisor, was the guiding force in shaping this dissertation. Dr. Phyllis Caroff gave generously of her time to help me with the study. Dr. Jesse Smith helped with the formulation of the initial project proposal and continued to offer advice and editorial judgment until its completion. My thanks also go to Dr. Irving Weisman who, as my advisor during earlier phases of the program, offered support and encouragement.

To my social work colleagues in hospitals in the New York metropolitan area who participated in this study, discussing, pre-testing instruments, responding to surveys and making suggestions, I offer my grateful appreciation. Special thanks are due to the administrators and staff of "East End Hospital" who welcomed me and shared with me their professional accomplishments and struggles. Without their support, interest and active participation, this study could not have been undertaken.

As often happens, life's crises intervened in the course of the study, bringing both joy and sorrow. I am

grateful to my friends and family for continuing to offer love and encouragement when I was pre-occupied. And, finally, special thanks to David for his scholarly assistance and his faith in me.

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CHAPTER I
PROBLEM FORMULATION AND REVIEW
OF RELATED LITERATURE

Introduction: The Problem

This study was undertaken to determine whether a program of support would help social workers cope better with the stresses they experience in working with cancer patients. The study's impetus came from concern that an increasing number of social workers become involved with cancer patients and their families, that the workers experience their work as stressful, and that they lack adequate supports to help them cope with the stresses experienced.

Cancer is the second greatest cause of death in the United States today. It has been estimated that in the 1970s there were 3.5 million cancer deaths, over 6.5 million new cancer cases, and more than 10 million people receiving medical care for the disease.¹

Because cancer is often a chronic disease, both its life-threatening nature and drastic treatment cause a series of major disruptions in the lives of patients and their families.² Oppenheimer, in a discussion of the use of crisis intervention with patients and families, states:

"The diagnosis of cancer with all its implications can be counted on to precipitate a state of crisis of varying intensity and duration for nearly every patient and his family."³

As a consequence of the catastrophic impact of cancer, and because so many families are affected,⁴ social workers are increasingly called upon to provide services both to patients and their families.⁵

Hospital social workers are developing programs to respond to extensive and continuing patient needs⁶ and are helping colleagues in other disciplines establish mutual support as they confront the emotional stress of working with cancer,⁷ but they themselves also exhibit the reluctance perceived among all health professionals to become involved with cancer patients.⁸ In the face of the painful emotions associated with cancer and its life-threatening implications, social workers, like other hospital staff members, often find work with cancer patients very stressful. In response to such stress, social workers often turn to coping strategies such as abbreviated or infrequent interviews which reduce their direct involvement with clients.⁹ This may occur at the very time when clients are most in need of the active service of the worker, as the social and emotional effects of the illness become apparent.

Although it is recognized that the prevalence and nature of the disease "may exact a heavy emotional toll from the social worker"¹⁰ and may cause stress for the many health professionals who work with cancer, the precise nature of the stresses experienced is not known.¹¹

A dramatic increase in both public and professional concern with dying patients is interwoven with interest in cancer and has led to attention to the needs of health professionals as well as patients "as they attempt to cope with the emotional demands of life-threatening illness."¹²

Although the need for support and training for staff engaged in this work has been increasingly recognized,¹³ there has been a lack of support programs for social workers, especially for those whose work with cancer patients is only one aspect of a mixed assignment.

This investigator's experience of many years in direct service, teaching and administration in social work programs, both in general hospitals and in a major cancer treatment center, led to a concern about the impact of cancer on patients, their families and the staff who assist them with their special problems.

From 1971 to 1973, as coordinator of postgraduate social work education at Memorial Hospital, New York, the investigator designed and implemented in-service training and continuing education programs for social workers in

relating to cancer and its consequences. More recent experience in surveying the field indicates that such training remains inaccessible to the majority of social workers in the community and general hospitals where most cancer patients receive their care. Existing training programs lack structures to provide ongoing support, and geographic limitations make attendance at long-term programs difficult for most workers.¹⁴

Although there has been increased interest in the field and growth of regional organizations of oncology social workers, those who are not primarily or exclusively assigned to an oncology team neither obtain specific training nor develop a network of interprofessional support to help them cope with the demands and stresses of their work with cancer.¹⁵ Yet their case-loads may be heavily weighted with cancer patients because of the complex physical, emotional and social consequences of the disease for patients and their families.¹⁶

Objectives of the Study

The objectives of this project include (1) a planning study to assess the need for special programs to help social workers cope with the stresses of their work with cancer and (2) an effort to design and implement an innovative program in one hospital to meet the needs determined. The target population of the needs assess-

ment consisted of social workers in general hospitals whose assignments include, but are not made up exclusively of, cancer patients.

The second, or implementation, phase of the study explored the nature and effects of a program of peer group support for social workers who are involved with cancer patients as part of their work. The model selected for the program, using peer group mutual support, is timely both because of recommendations for support emerging from numerous studies of worker burnout¹⁷ and because of increasing professional recognition of the value and importance of mutual aid as a helping system.¹⁸ Development and effects of the program were systematically monitored and evaluated and the findings reported.

The search of the literature and exploration of knowledge relevant to the unmet need which, together with the investigator's experience in the field, led to identification of the need for this study, are reviewed in this chapter. A needs assessment survey, which was undertaken, provided detailed data about the existing need. The methodology and findings of the survey, which generated ideas for the program's design and development, are reported later in the project.

Review of the Literature and Related Knowledge

Exploration of the literature has focused on knowledge relevant to the study's purpose and primary

objectives. Because of the study's assumption that their experience of stress diminishes the ability of social workers to perform optimally in their work with cancer patients, a primary area for exploration was a search for detailed knowledge of the nature of the problems experienced by social workers in the cancer field. The specific nature of their stresses was also explored in the needs assessment of this study and used in the formulation of the study design. (See Chapter II for report of needs assessment.)

Research on worker burnout, widely reported in recent professional literature, was reviewed because it seemed closely related to the study's exploration of stress and coping in social work with cancer patients.

For the study's objective of designing a model program of support to respond to the problems and special needs of social workers in the cancer field, knowledge related to the nature and development of support programs was investigated. Although peer support programs are advised¹⁹ and described for those experiencing job stress,²⁰ in the absence of a single body of knowledge offering a theoretical base for the model support program, this study explored the notions of coping and support as areas of knowledge which would provide relevant theory and information.

Thus, the areas of the literature reviewed as pertinent to the study's purpose are related to notions

of stress, burnout, coping and support.

Cancer and Stress

Studies have reported the stressful emotional impact of cancer on patients and their families. Bard states that:

Cancer patients must be regarded as people under a special and severe form of stress. Cancer is commonly perceived as an always-fatal and particularly loathsome disease, not 'clean' and uncomplicated like, for example, the frequently more fatal heart disease. In addition to the expectation of prolonged and intense pain, it carries the threat of disability and, even more frighteningly, recurrence and the repeated threat of death. Thus cancer becomes an unusually stressful experience which disrupts the most important lifelong patterns of behavior.²¹

Literary and popular references to cancer have long associated the illness to pain, disfigurement and death, and a quality of mystery is attached to the disease which still contributes to its impact on patients, their families, health care personnel and the general population. Sontag has pointed out the pervasive use of cancer as a metaphor implying evil, invasion or death.²²

Despite its continued association to death, during the 1970s, cancer received considerable attention from the media and government. The National Cancer Act of 1971 gave sanction to a national "war on cancer," which thereby ceased to be an unspeakable word.

A concurrent surge of interest in terminal illness, evidenced by extensive literature and the establishment of organizations devoted to the study and care

of the dying, has to some extent counteracted reluctance to become involved with the dying.²³ Many cancer patients, however, are not dying but living with the complex social and emotional problems of a changed and very stressful reality.²⁴ As one patient, cured of Hodgkin's Disease, stated:

Ours are the problems of surviving a disease which most people assume is fatal. They are the emotional problems of never having met someone who's survived, of worrying alone that the lumps will return and of knowing of no one who understands.²⁵

Although the growing cancer population now includes cured patients, the illness remains catastrophic, and is frequently chronic, and treated in ways that drastically interfere with normal life-styles.²⁶ As Judith Ross has stated, "The universal fear of the disease and its connection with death in people's thinking, thrust its victims into a unique crisis."²⁷

The complexity of cancer patients' problems as they face multiple crises, role changes and changed expectations on the part of others, together with a prevailing attitude of hopelessness about the illness, make them a population frequently in need of social work services. While some social work programs offer unique and effective services to cancer patients and their families,²⁸ on the whole social work's response to the stress and crisis of cancer has been characterized by fear, avoidance and over-identification.²⁹

Staff Reactions

Staff of all disciplines frequently avoid prolonged contacts and emotional involvement with dying patients.³⁰ Although there is a scarcity of adequate empirical studies of the psychosocial impact of terminal illness on both caretakers and survivors, anecdotal evidence suggests that professionals experience strong affective reactions.³¹ These have been exemplified as follows:

Patients and medical personnel alike tend to assume that physicians, nurses, social workers, and other caregivers are immune to the stress, anxiety, and misconception surrounding cancer. In reality, health professionals are subject to the same emotions and fears their patients experience. And they deal with those emotions and fears in much the same way: They become angry; they deny the truth; they avoid the problem. If these defense mechanisms are carried to the extreme, they can isolate the health professional from his patients and coworkers.³²

In a discussion of the social responsibility of institutions concerned with the dying, Lohmann comments on the personal relationships which may develop between long-term patients and their caregivers. When such relationships occur, the staff are subject to loss and grief when the patients die.³³

In a paper on education of professional students for work with terminally ill patients and their families, Caroff and Vigilante note the "normal stress response among all students whose work requires that they face their own mortality in the process of becoming professional."³⁴ Differences were noted, with older students better able to cope with the stresses they experienced.³⁵

Recognition of personal mortality and the stress that accompanies it seems inevitable for any social worker who becomes involved with cancer patients and their life-threatening disease. Solkoff points out that it is not only the reality or immediacy of dying which seems to have such an impact on the professional caregivers.

Until recently, the fear of death associated with cancer was so pervasive that the medical and social-service community even neglected those cured patients who, as a result of their treatment, have to live with practical physical problems.³⁶

This patient's view of the dysfunctional impact on professionals of the association of cancer with death is supported by the statement that: "Like their patients, health professionals may view cancer as inevitably leading to death, and dealing with the cancer patient may raise serious conflicts in the caregiver's mind about death and his power to prevent it."³⁷

The Experience of Stress

In everyday language, stress is used to refer both to stressor, or anxiety-producing stimulus, and to reactions to the demanding circumstances.³⁸ In relation to stress and coping by health professionals in the cancer field, the definition of stress "requires that we use the term only when speaking of those physiological and emotional responses that accompany exposure to threatening life experiences."³⁹ The term stressor is

used to denote those environmental circumstances in which stress is elicited.⁴⁰

As in the case of other stress-producing situations, the diagnosis, course and treatment of cancer initiate reactions and attempts to cope with a set of threats or stressors. Individuals adapt in a variety of ways to the changed situation produced by the stressor.⁴¹ The task of managing or coping with stress is an important determinant of the quality of people's lives.⁴² In the case of cancer patients, whose lives themselves are threatened, both the patients and their families use a variety of means of coping with stress. In a study of the coping behavior of patients and their families as they faced the life-threatening diagnosis of brain tumor, it was found that many adapted to their profoundly difficult conditions by means of avoiding and denying the serious implications and potential outcome of the illness.⁴³

While avoidance has been a major means of coping on the part of professionals also, in recent years it has been suggested that the climate of avoidance among social workers has decreased, as evidenced by their growing participation in programs related to cancer.⁴⁴ Special training programs offered new knowledge and skills to meet the needs of cancer patients but workers continued to return to assignments and hospitals in which there was no structure to sustain either increased recog-

nition of patients' needs or heightened self-awareness of the worker.⁴⁵ Social workers in community and general hospitals lacked opportunities to develop mutual support groups, to teach others newly acquired skills or knowledge and to maintain gains from specialized education. Therefore, it seems that for many social workers the experience of working with cancer patients remains characterized by stress.

Despite considerable research interest in stress and coping, this search of the literature revealed a lack of systematic study of social workers' job stresses and ways of coping. In a recent paper proposing the identification of stress for social workers in health care in order to prevent burnout, it is noted that there has been no research examining stress experienced by social workers providing services in a hospital.⁴⁶ Another study which identified coping strategies used by an interdisciplinary group of health care workers who worked with cancer patients did not specifically focus on strategies or stresses of the social workers who participated.⁴⁷

Burnout

Burnout refers to a pattern of worker responses to stressful roles and tasks.⁴⁸ The burnout syndrome has been well-documented in, among others, the field of child welfare, and particularly in relation to child abuse and

neglect.⁴⁹ The response pattern is characterized by reduced involvement with clients, withdrawal from the original meaning or purpose of the work, physical exhaustion and emotional feelings of failure, even among those regarded by others as competent professionals. Causes of burnout are reported to be problems which have not been adequately acknowledged or dealt with, such as heavy caseloads, the absence of opportunities to experience completion or success, unfinished work and lack of preparation for the unique emotional demands of the work.⁵⁰ Emotional exhaustion is said to result from interpersonal contacts charged with intense feelings.⁵¹ Maslach suggests that little effort was made to understand or deal with what happens to professionals in such situations because staff's negative feelings towards clients have been a taboo topic.⁵²

The burnout concept seems equally relevant to the cancer field where staff members are involved in numerous and repeated emotionally-charged relationships with patients, their families and professional colleagues. Successful outcomes are few and far between, especially if, within the dominant medical environment, goals are perceived in cure terms rather than based on realistic social and emotional change potential. In studies of burnout among direct service providers and social work advocates, researchers have explored the relationship between burnout and length of worker experience.⁵³ More

experienced workers were found to be less burned out than new workers in the field. The conclusion was drawn by Streepy that a lack of appropriate education and training might in part account for the findings. It seemed that workers prone to burnout might leave the profession before they could attain advanced education or acquire helpful experience.⁵⁴ It was also speculated that negative attitudes towards the social work profession "may contribute to the development of burnout by increasing workers' emotional exhaustion and detachment from the original purpose of their work."⁵⁵

Streepy's findings supported the suggestion that workers who could be considered as burned out on other characteristics demonstrated increased distance and decreased involvement in the worker-client relationship.⁵⁶

Other studies have also identified a coping system based on withdrawal.⁵⁷ The burnout syndrome, with its pattern of withdrawal, appears to result from the "interaction of several factors that tend to produce or maintain stress on service providers."⁵⁸ Suggestions for alternate coping strategies such as training, time-out, mixed caseloads and support programs emerge from several studies.⁵⁹

Coping

The concept of coping has been used interchangeably with notions of mastery, defense and adaptation.⁶⁰

According to Perlman, coping is an effort to "deal with some new, and often problematic, situation or encounter or to deal in some new way with an old problem. Its purpose is mastery or problem-solving at best; at the least, it serves to reduce tension and ameliorate the problem."⁶¹ In this sense, coping is a conscious effort which involves modifying thoughts or feelings, examining options and using available feedback to help with decisions.⁶²

Pearlin and Schooler define coping as a response to a life-strain that serves to prevent, avoid or control emotional distress. By strains they mean "enduring problems that have the potential for arousing threat, a meaning that establishes strain and stressor as interchangeable concepts."⁶³ From research which explored a range of ways of coping, the authors conclude that: "Coping, in sum, is certainly not a unidimensional behavior. It functions at a number of levels and is attained by a plethora of behaviors, cognitions and perceptions."⁶⁴ While it was traditionally considered that the ability to cope was a personality characteristic such that "having the 'right' personality characteristics enables one to deal with life-problems effectively,"⁶⁵ Pearlin and Schooler's research leads them to conclude that the "sheer richness and variety of responses and resources that one can bring to bear in coping with life-strains may be more important in shielding one's self from emotional stress than the nature and content of any

single coping element."⁶⁶ They also suggest that some important human problems such as those within one's occupation may not be responsive to individual coping mechanisms and that "Coping with these may require interventions by collectivities rather than by individuals."⁶⁷

The social context of coping and adaptation is pointed out by Mechanic, who stresses the importance of social supports and the influence of social networks on adaptive behavior.⁶⁸ A group may have influence on the development of mastery "through specialization of function, pooling of resources and information, developing reciprocal help-giving relationships and the like."⁶⁹ Among the components of coping behavior identified are many that depend on social interaction such as appraisal, motivation, information seeking, contingency planning rehearsal, feedback and social influences.

Withdrawal

Withdrawal or resistance as a means of coping by professionals has been identified as common practice when the population is dying or in a critical life phase, such as old age, that stirs up emotional responses from the worker.⁷⁰ Psychiatry recognized that therapists may develop countertransference reactions based on the patient's physical qualities and that poor treatment may result. In the case of the cancer patient, workers' fears of the illness may deflect the focus away from the

real interests of the patients. Recently, the notion of countertransference has been expanded to include the transfer of feelings towards others in the present life of the worker into the relationship with a client, or even to include responses, such as anger, that are evoked by the client's actions but inappropriate for the worker to respond to within the professional role.⁷¹ Mary Schwartz suggests that the worker "must not only come to understand his or her own reactions but must also be able to use that understanding to change the feelings experienced toward the client."⁷²

As Reid states, the worker, like the client, "brings to the helping relationship his own humanness. In spite of his training, he is a human being first and a professional person second."⁷³ The worker may have difficulty because of aspirations to heal, know and love all, and may be frustrated because the helping process is neither smooth nor fast. Clients may question the worker's ability to help or may resist such efforts, with the potential result "of raising doubts of his own competence in the worker's mind."⁷⁴ Reid notes that the helping professionals became "less absorbed with transference and resistance analysis and more interested in the tremendous role played by the therapist's own personality within the helping relationship."⁷⁵ Yet, assessment of his/her emotional involvement is problematic for the helper, whom Reid perceives as caught "between two power-

ful forces; on one side is his professional commitment to helping the client, and on the other is the very human personal reaction he is having to the client."⁷⁶ In order to deal with these reactions, the worker needs to "keep the impulses triggered by the client at a conscious level" and must be "sensitive to his own blind spots so as to prevent them from interfering in the therapeutic process."⁷⁷

Support

Major work in the area of support has been undertaken by Caplan.⁷⁸ He defines social support systems as enduring interpersonal ties to groups of people who can be relied upon to provide emotional sustenance, assistance and resources in times of need, who provide feedback and who share standards and values. Within a support system feelings can be shared without fear of condemnation. The benefits to an individual of a support system include the social-emotional supports of regular, friendly interaction with others in a similar situation who share concerns and help with current tasks, provided by those who have handled similar situations and can report the outcomes. He identifies three elements of support, constituting ways in which individuals are helped by others. He states that:

...the significant others help the individual mobilize his psychological resources and master his emotional burdens; they share his tasks; and they provide him with extra supplies of money, materials,

tools, skills and cognitive guidance to improve his handling of the situation.⁷⁹

Cobb, in studying the role of social support in moderating the impact of stress on patients, defines social support as information in one of the following categories:

1. Information leading the subject to believe that he is cared for and loved.
2. Information leading the subject to believe that he is esteemed and valued.
3. Information leading the subject to believe that he belongs to a network of communication and mutual obligation.⁸⁰

The notion of information is central to the concept of social support, which Cobb perceives as a facilitating factor for coping with crisis and adaptation to change. He cites evidence that mastery of a new task takes place best under supportive conditions and recommends investigation of the moderating effects of social support on the consequences of a variety of life transitions.⁸¹

Support is also seen as a necessary condition for change by Nelsen, who distinguishes four types of support which workers may offer to clients: protection, acceptance, validation and education.⁸²

Support thus defined is provided by procedures intended to help clients feel "better, stronger, or more comfortable in a fairly immediate way."⁸³ Nelsen also places high value on support of social workers within

their job settings. She states that:

Social workers should also be aware that when they do not receive support within their professional settings, they may be less able to offer support to their clients.⁸⁴

She proposes that workers should be accepted and validated by professional colleagues, should receive continuing educational opportunities and enough support to feel able to examine their own behavior towards clients. Nelsen suggests that in the absence of such favorable conditions burnout is likely to occur.⁸⁵

Components of Support

The components of support include confirmation that one is valued by others, feedback indicating in what ways one is doing well or likely to be effective, and encouragement of coping efforts. The educational component of support helps people to learn by building upon what they already know, providing new information and giving guidance when necessary.

In small groups established for mutual assistance in stressful life situations, support components have been identified as social support, opportunities for emotional interaction and sharing factual information about the stress area. Marc Schwartz states that: "Information reduces uncertainty and reduces the threat of the unknown. It can help members find new strategies and gratifications."⁸⁶

Barish concludes that information which is shared is not typically available in books and he states that:

Information, including both technical and anticipatory guidance on expectable problems and phases or transitions, is an important element in almost all mutual help organizations. What constitutes 'help' is often a new definition of the problem and specific information about the practicalities learned through experience and shared with others because it 'works'.⁸⁷

In addition to information not previously accessible or which had not formerly appeared relevant to the group member, comparison of responses and activities with those of other members can be the basis for new learning. Killilea reports on research which suggests that such comparisons stimulate a process of self-examination which can lead to new insights.⁸⁸ Feedback from other members may serve a function similar to sharing and comparisons, as through feedback members learn the effects of their actions as perceived by others and are, at the same time, provided with alternate models of behavior.

Another aspect of the support mechanism is the helper therapy principle which states that even when the recipient of help, in this case the peer group member, receives minimal help from an action or piece of information, the helper profits from his role.⁸⁹ Thus in a mutual aid group, a member explaining an activity in relation to cancer patients would gain renewed understanding of the activity through the process of explaining it. Group members may receive a great deal of help; the

helper therapy principle merely calls attention to the aid simultaneously received by the helper.⁹⁰

Staff Support

Caplan voices concern for professional caregivers who, much like families supporting a member through a crisis, "might themselves become upset while they were supporting the families."⁹¹ He proposes the establishment of programs of "support for the supporters."⁹² Similarly, literature about the phenomenon of burnout strongly recommends support programs.⁹³

When examining the coping strategies of a group of staff of several disciplines involved in the care of cancer patients, Koocher notes that mutual support "is critical to coping with day-to-day stresses."⁹⁴ He suggests that such support can be accomplished with "formal support group meetings or routinely scheduled informal rap sessions."⁹⁵ Although some hospital social work departments have used forms of peer group support in relation to job stress, there are few reported examples and a lack of systematic study to explore either the components of such support or its specific effects on the problems involved.

There are no studies of the effects of a structured support program in reducing job stress or reinforcing specialized training for work with cancer patients, but some attention has been paid to the use of

peer groups for staff supervision and learning. A recent study suggests that all members of such groups share responsibility and that each member "functions as a resource for the professional growth and development of self and others."⁹⁶

One hospital social work department developed peer groups for supervision with the expectation that the workers "would be able to tolerate the give-and-take of group learning as well as to take responsibility for sharing and listening in such a milieu."⁹⁷ The group process was found to facilitate learning and some anxiety was reduced "by the supportive structure of the group, which could concretely universalize such feelings by sharing them."⁹⁸

Mutual Aid

Literature on self-help and mutual aid also offers theory explaining the nature and effects of mutual support in group situations. Since Kropotkin wrote his seminal work which describes the process of people banding together for mutual aid throughout the evolution of society,⁹⁹ the notion of mutual aid has come to have many meanings and applications. Killilea describes ways in which mutual aid becomes a theme of diverse systems and an element of various social organizations. It may be seen as a therapeutic method, an adjunct to professional services, or a social movement among many defini-

tions and uses of the term.¹⁰⁰

Katz states that "the essence of mutual aid has been the need for and creation of group coping mechanisms that ensure man's survival in the face of environmental threats and deprivations."¹⁰¹ Help within a mutual aid or mutual support group takes the form of helpers acting as role models and teachers for their peers. A mutual help group is formed around a common problem and its members use their common experience to find solutions or to learn from each other ways of dealing with their common difficulty.¹⁰²

Mutual aid is a more comprehensive and generic term than self-help and may be a more appropriate label for the range of groups offering mutual help between members. However, a distinction may be made between mutuality and self-help, although both may exist in a self-help group. Self-help places emphasis on the individual's own activity, while stimulated and supported by the other members.¹⁰³ Mutual aid, however, implies that help is given by some to others, with an expectation of reciprocity.¹⁰⁴

The helping process in a mutual aid group contains the following elements: social reinforcement, training and support for particular behavior, modeling of methods of coping, development of ideas for change in the stressful environment, removal of mystification about the problem area and exchange of information. Thus the range

of perceptions of the problem and of actions which members might take to improve coping is expanded.¹⁰⁵ Members reduce their sense of isolation and uniqueness through comparison with others and they validate the appropriateness of feelings.¹⁰⁶ Leadership in mutual aid groups is, at least in theory, diffused and shared. Mutual aid groups empower their members in a process that combines properties: there may be professional involvement, an influential ideology, persuasion, commitment and the value to the helper of helping others. The common theme of the groups is sustaining the members' ability to cope.¹⁰⁷

Most mutual aid groups include informal information sharing and have formal sessions with specialist speakers or formal discussion periods at group meetings. Marc Schwartz suggests that the mutual aid group, in his terminology a situation/transition group, "can help its members develop a cognitive framework within which to structure events and feelings that evolve from the shared life concern."¹⁰⁸

Self-help Groups

The notion of mutual aid is central to the purpose and the functioning of self-help groups and organizations. There is a large number of such groups, encompassing a range of models, from leaderless to authoritarian. Self-help groups come together to accomplish a

common purpose through mutual aid between members, and usually in the absence of professional intervention. Sometimes a charismatic leader takes the role assumed by a professional in other types of groups.¹⁰⁹

The development of the self-help movement has been labelled a "profound critique of professionalism."¹¹⁰ Although the importance of support is recognized in social work practice, social workers, like other professionals, were hesitant to support self-help groups. In the absence of such professional interest, a number of cancer self-help groups, such as Reach to Recovery, were developed. Later attempts by professionals to enter such groups have not always met with success.¹¹¹ In some groups, professionals are involved but not dominant.¹¹² Katz states that "Self-help groups are rather peer-related support groups."¹¹³

Leadership

Mutual aid groups frequently have leaders of one kind or another. Such leaders, even if professionals, may function as peers, participating in mutual support and interchange.¹¹⁴ Kaplan and Glenn report that a self-help group with leaders acting as peers was a base for training members to move into leadership roles in similar mutual aid groups.¹¹⁵

Peer support groups may be seen as "work" groups in Turquet's terms, in that they are formed for the pri-

mary task of developing mutual aid around a common issue.¹¹⁶ The leader of a work group is a peer who, like other members of the group, has skills for their intended task.¹¹⁷

This form of leadership is contrasted with that of a "basic-assumption group" such as a therapy group. In such groups there is "never a question of equals" in respect to leadership,¹¹⁸ and the leader is expected to be omnipotent and to "act without the group's having to indicate its action wishes."¹¹⁹

In its pursuit of its task, a work group maintains a relationship to its environment which complicates the leadership function. Leadership, therefore, "has to be Janus-like, looking both internally and externally, becoming both participant and observer."¹²⁰

In contrast to notions of peer leadership, Caplan suggests that the goals of a peer support group are best achieved if moderated by an outside leader of higher status who can help members evaluate themselves and others constructively.¹²¹

Peterson, in a program which used mutual aid and a peer support group to enhance students' learning, perceived the role of the leader as "to facilitate the process by which the peer group can mobilize itself in the desired direction."¹²² This involved acting as enabler, information resource and behavior model. The leader, who was also the classroom instructor and responsible for

the provision of didactic information, sought to foster mutual aid by intervening in discussions only when assistance was needed. In a study of supportive discussion groups for new teachers under stress, Beach, Levine and Goldberg review the role of the leaders who were psychologists and social workers.¹²³

The leader's role was one of facilitating the discussion, helping to keep it focused and trying to minimize resistance and defensiveness. Group process occasionally became the focus of attention, but leaders tried to maintain the task orientation as much as possible.¹²⁴

The contract of the teachers' groups was open to continual redefinition, "often rendering the leader uncertain about how to proceed."¹²⁵

The study's development highlighted the importance of the nature of the contract established between the leader and the group of professionals.

In an article about the need for support, both on and off the job, for workers whose day-to-day experiences are emotionally draining, Bandoli discusses leaderless support groups.¹²⁶ He suggests that such groups have emerged because of "the lack of adequate support systems or inadequacies of those in existence."¹²⁷

Such a group is itself "the primary helping source" and must "collect and direct its energy without the aid of a formal, designated leader."¹²⁸ Bandoli suggests that such groups may be part of a trend towards greater self-direction on the part of social service per-

sonnel. In one example of a leaderless support group, formed by coworkers in child protective services, the group took considerable time to evolve and develop trust but ultimately became a strong source of support for its members. Bandoli notes that the group's success may depend on the participation of "mature, highly motivated individuals who have already developed some trust in one another."¹²⁹ A support group of this type is seen as an aid to supervision in the task of sustaining workers who face emotionally stressful situations.

Implications for the Study

A review of related literature revealed support for the assumption that the emotional impact of cancer causes job stresses for social workers who work with cancer patients. The research of psychologists, psychiatrists, social scientists and social workers documented the universally stressful effects of this chronic and life-threatening illness. Literary references and statements of patients support the conclusions of social workers and others who have studied the professional care system that staff involved with cancer patients experience considerable stress in their work. Support for the assumption that this study would break new ground in its documentation of the difficulties reported by a group of social workers in a general hospital was derived from the discovery of a lack of systematic study of the specific

problems of such workers.

The assumption was also confirmed that social workers, like other professionals, cope with job stresses by withdrawing from emotional involvement with their clients. The rich body of literature on burnout, coping and adaptation, resistance and countertransference posed questions for the study about the extent to which social workers involved with cancer patients use withdrawal as a means of coping and whether they indeed "burn out" or are never "on fire"¹³⁰ but, finding the job very stressful, avoid involvement from the beginning. These questions indicated the importance for the study of identifying the coping patterns of its participants, social workers in general hospitals, and lent support to the assumption that some of the workers' coping patterns might adversely affect service to the clients. The need was made clear for a program which would help social workers to recognize such patterns and enable them to change their coping behavior as a consequence of that recognition.

Thus, the primary goal of the study was the exploration of the nature of the stresses and coping patterns of social workers in general hospitals who are involved with cancer patients as part of their work.

The second goal of the study, to develop a model program which could support the workers, enhance their coping repertoire and include evaluation of the program's effects, became more clearly defined as the existing re-

search was reviewed. Research on burnout and coping recommended the establishment of such programs in an effort to increase the quality of client service. Previous research on support, coping, mutual aid and self-help encouraged the assumption that any changes in coping behavior would be most likely to occur within an atmosphere of support.

Theoretical explorations of the nature of support, resting on the basic assumption of the inter-relatedness of knowledge and emotional responses, helped to formulate the study's plan for program development. Recognition of the importance of the helper therapy principle in the mutual aid process led to the decision to develop a model of peer group mutual support, through which members would both gain new ideas and help others. Since the literature on support, coping and mutual aid noted information sharing as a major component, plans for the program emphasized an exchange of information between participants to increase knowledge and improve coping skills. Some apparent gaps in knowledge about the specific components of support suggested the importance for this study of identifying elements of teaching and learning essential to the enhancement of coping, and which might provide a basis for future training curricula.

Notions of leadership for peer groups were explored and offered some guidelines for the program. Since mutual aid was the core notion of the program, the

role of the investigator as expert leader or consultant, within a peer group formed for mutual support around a specific topic of interest, required careful planning. As little conclusive material was available related to such a leadership role, the study's findings about the group's need and uses of leadership, and any changes which might occur during the program, were identified as important aspects of the study.

Thus, the review of the literature supported the investigator's identification of the need for this study. The gap in knowledge was further confirmed by a needs assessment survey which provided detailed data about social workers' stresses and ways of coping with work in the cancer field.

The methodology and findings of the needs survey, which generated ideas for the program's design and development, are incorporated in Chapter II which describes the design of this study. In Chapter III the process of the program's development and findings are reported. Evaluation of the project is reported in Chapter IV, and Chapter V provides a summary and consideration of the study's implications for practice and further research.

CHAPTER I FOOTNOTES

¹Cancer Facts and Figures, 1981 (New York: American Cancer Society, 1980).

²Jeanette R. Oppenheimer, "Use of Crisis Intervention in Casework With the Cancer Patient and His Family," Social Work 12:2 (April 1967), p. 44. See also Barbara E. Kaplan and Frances J. Hurley, "Head and Neck Cancer: A Threat to Life and Social Functioning," Social Work in Health Care 5:1 (Fall 1979), pp. 51-58; and Judith W. Ross, "Coping With Childhood Cancer: Group Intervention As An Aid To Parents In Crisis," Social Work in Health Care 4:4 (Summer 1979), pp. 381-391.

³Oppenheimer, op. cit., p. 44.

⁴Cancer Facts and Figures states that: "Almost 56 million Americans now living will eventually have cancer; one in four, according to present rates. Over the years, cancer will strike in approximately two of three families."

⁵Findings of the needs survey of this study indicate that hospital social workers in general hospitals spend a high proportion of their time working with cancer patients. The mean percentage of total caseloads involving cancer patients reported by survey participants was 25% but for some workers the figure was as high as 75%. Twenty-five per cent of the workers reported seeing between eleven and twenty-five cancer patients per month.

⁶Margaret Domanski et al., "Comprehensive Care of the Chronically Ill Cancer Patient: An Inter-agency Model," Social Work in Health Care 5:1 (Fall 1979), pp. 59-70; and Linda F. Barstow, "Working With Cancer Patients in Radiation Therapy," Health and Social Work 7:1 (Feb. 1982), pp. 35-40.

⁷Mildred Mailick, "The Impact of Severe Illness on the Individual and Family: An Overview," Social Work in Health Care 5:2 (Winter 1979), pp. 117-128; and Carleton Pilsecker, "Terminal Cancer: A Challenge for Social Work," Social Work in Health Care 4:4 (Summer 1979), p. 378.

⁸Samuel C. Klagsbrun, "Cancer, Emotions and Nurses," American Journal of Psychiatry 126:9 (March 1970), pp. 71-78.

⁹Pilsecker, op. cit., p. 370.

¹⁰Ibid.

¹¹Gerald P. Koocher, "Adjustment and Coping Strategies Among the Caretakers of Cancer Patients," Social Work in Health Care 5:2 (Winter 1979), pp. 145-150.

¹²Richard A. Kolotkin, "Preventing Burn-Out and Reducing Stress in Terminal Care: The Role of Assertive Training," in Behavior Therapy in Terminal Care, ed. Harry J. Sobel (Cambridge, Mass.: Ballinger Publishing Co., 1981), p. 229.

¹³Specialized training in social work with cancer patients is available at major cancer centers, such as Memorial Hospital in New York, The Sidney Farber Cancer Institute in Boston and through the American Cancer Society in California.

¹⁴Ibid.

¹⁵For example, The Oncology Network, an organization of social workers in oncology in New York City and SWOG, an organization in Massachusetts (Social Work Oncology Group). For an example of a multidisciplinary network, see Domanski, p. 70.

¹⁶Domanski, op. cit., p. 59; and Note 5, above.

¹⁷For example, Ayala Pines and Ditsa Kafry, "Occupational Tedium in the Social Services," Social Work 23:6 (Nov. 1978), pp. 499-507.

¹⁸For example, Gerald Caplan, Support Systems and Community Mental Health (New York: Behavioral Publications, 1974).

¹⁹Literature on "burnout" includes exhortations for support to be offered. See, for example, Pines and Kafry, op. cit. There are similar recommendations in Coping With Cancer: A Resource for the Health Professional, U.S. Department of Health and Human Services, September 1980.

²⁰For example, Stuart Copans et al., "The Stresses of Treating Child Abuse," Children Today 8:1 (Jan./Feb. 1979), pp. 22-27.

²¹Morton Bard, "The Psychological Impact of Cancer and Cancer Surgery," in Proceedings of the American Cancer Society's National Conference on Human Values and Cancer (A.C.S. 1972), p. 24. See also Arthur M. Sutherland and Charles E. Orbach, "Depressive Reactions Associated With Surgery for Cancer," in The Psychological Impact of Cancer (New York: A.C.S. Inc., 1977), pp. 17-21.

²²Susan Sontag, Illness As Metaphor (New York: Farrar, Straus and Giroux, 1977).

²³See for example, Elisabeth Kübler-Ross, On Death and Dying (New York: Macmillan, 1970); Bernard Schoenberg et al., Anticipatory Grief (New York: Columbia University Press, 1974); and Barney Glaser and Anselm Strauss, Awareness of Dying (Chicago: Aldine Publishing Co., 1965).

²⁴Barbara E. Kaplan and Frances L. Hurley, "Head and Neck Cancer: A Threat to Life and Social Functioning," Social Work in Health Care 5:1 (Fall 1979), p. 51.

²⁵Joel Solkoff, "Learning to Live Again," The New York Times, June 4, 1978, VI, p. 100.

²⁶Domanski, op. cit.

²⁷Ross, op. cit., p. 381.

²⁸Roberta Klein, "A Crisis to Grow On," Cancer 28 (1971), pp. 1659-1678; and Domanski, pp. 62-63.

²⁹Pilsecker, op. cit., p. 372.

³⁰Kübler-Ross, op. cit; and Glaser and Strauss, op. cit.

³¹Kolotkin, op. cit., p. 229.

³²Coping With Cancer, op. cit., p. 87.

³³Roger A. Lohmann, "Dying and the Social Responsibility of Institutions," Social Casework 58:9 (Nov. 1977), p. 544.

³⁴Phyllis Caroff and Florence Vigilante, "Age Specific Issues In Educating Professionals to Work With Terminally Ill Patients and Their Families," Journal of Gerontological Social Work 1:4 (Summer 1979), p. 334.

³⁵Caroff and Vigilante, op. cit. The significance of this aspect of their discussion for this study is reviewed in Chapter II.

³⁶Solkoff, op. cit., p. 110.

³⁷Coping With Cancer, op. cit., p. 87.

³⁸Sol Levine and Norman A. Scotch, Social Stress (Chicago: Aldine Publishing Co., 1970), p. 9; and Kolotkin, op. cit., p. 232.

³⁹Kolotkin, op. cit., p. 232.

⁴⁰Ibid.

⁴¹Levine and Scotch, op. cit.

⁴²Ibid., p. 280.

⁴³Aileen Hung, "Coping Behavior of Patients and Their Families to a Life-Threatening Illness (Brain Tumor)," (D.S.W. dissertation, Columbia University, 1976), p. 381.

⁴⁴For example, Memorial Hospital in New York; SWOG in the Boston area and the American Cancer Society in California.

⁴⁵Observations of the investigator, confirmed in an interview with Ms. Virginia Conkling, Social Work Consultant of the American Cancer Society, on September 10, 1981.

⁴⁶Susan Taylor-Brown et al., "Stress Identification for Social Workers in Health Care: A Preventive Approach to Burn-Out," Social Work in Health Care 7:2 (Winter 1981), pp. 91-100.

⁴⁷Koocher, op. cit.

⁴⁸Herbert J. Freudenberger, "Staff Burn-Out," Journal of Social Issues 30:1 (1974), pp. 159-165; and Ayala Pines and Christina Maslach, "Burn-Out in Mental Health Professionals," in Proceedings of Second Annual Conference on Child Abuse and Neglect, Vol. 2, (Austin, Texas) 1977, pp. 239-245.

⁴⁹Frank Schneiger, "The Worker Burnout Phenomenon: Implications of Current Research for the Child Protective System," Child Abuse and Neglect, Special Newsletter 1 (Nov. 1978), pp. 1-10; and Copans, pp. 22-27.

⁵⁰Herbert J. Freudenberger, "Burn-Out: Occupational Hazard of the Child Care Worker," Child Care Quarterly 6:2 (Summer 1977), pp. 90-99; and Ayala Pines and Christina Maslach, "Characteristics of Staff Burnout in Mental Health Settings," Hospital and Community Psychiatry 29 (April 1978), pp. 233-237.

⁵¹Christina Maslach, "Job Burnout: How People Cope," Public Welfare 36 (Spring 1978), pp. 56-58.

⁵²Ibid.

⁵³Irwin Epstein, "Advocates on Advocacy: An Exploratory Study," Social Work Research and Abstracts 17:2 (Summer 1981), pp. 5-12; and Joan Streepy, "Direct Service Providers and Burnout," Social Casework 62:6 (June 1981), pp. 352-361.

⁵⁴Streepy, op. cit., p. 360.

⁵⁵Ibid., p. 361.

⁵⁶Ibid.

⁵⁷For example, Charles C. Larson, David L. Gilbertson and Judith A. Powell, "Therapist Burn-Out," Social Casework 59:9 (Nov. 1978), pp. 563-565.

⁵⁸Streepy, op. cit., p. 361.

⁵⁹Robert Kahn, "Job Burnout: Prevention and Remedies," Public Welfare 36 (Spring 1978), pp. 61-63; Copans, p. 22; and Larson, pp. 564-565.

⁶⁰Robert W. White, "Strategies of Adaptation: An Attempt at Systematic Description," in Coping and Adaptation, eds. George V. Coelho, David A. Hamburg and John E. Adams (New York: Basic Books, 1974), pp. 47-68.

⁶¹Helen Harris Perlman, "In Quest of Coping," Social Casework 56:4 (April 1975), p. 213.

⁶²Ibid., pp. 215-218.

⁶³Leonard I. Pearlin and Carmi Schooler, "The Structure of Coping," Journal of Health and Social Behavior 19 (March 1978), p. 3.

⁶⁴Ibid., pp. 7-8.

⁶⁵Ibid., p. 12.

⁶⁶Ibid., p. 14.

⁶⁷Ibid., p. 18.

⁶⁸David Mechanic, "Social Structure and Personal Adaptation: Some Neglected Dimensions," in Coping and Adaptation, eds. Coelho, Hamburg and Adams, pp. 32-44.

⁶⁹Ibid., p. 35.

⁷⁰Kübler-Ross, 1970, op. cit.; and Kenneth E. Reid, "Nonrational Dynamics of the Client-Worker Interaction," Social Casework 58:10 (December 1977), p. 603.

⁷¹Mary C. Schwartz, "Helping the Worker With Countertransference," Social Work 23:3 (May 1978), pp. 204-209.

⁷²Ibid., p. 204.

⁷³Reid, op. cit., p. 601.

⁷⁴Ibid., p. 602.

⁷⁵Ibid.

⁷⁶Ibid., p. 605.

⁷⁷Ibid., p. 606.

⁷⁸See for example, Gerald Caplan, Support Systems and Community Mental Health (New York: Behavioral Publications, 1974); and Gerald Caplan and Marie Killilea, eds., Support Systems and Mutual Help: Multidisciplinary Explorations (New York: Grune and Stratton, 1976).

⁷⁹Caplan, op. cit., p. 6.

⁸⁰Sidney Cobb, "Social Support As A Moderator Of Life Stress," Psychosomatic Medicine 38:5 (September/October 1976), p. 300.

⁸¹Ibid., p. 312.

⁸²Judith C. Nelsen, "Support: A Necessary Condition for Change," Social Work 25:5 (September 1980), pp. 388-392.

⁸³Ibid., p. 388.

⁸⁴Ibid., p. 390.

⁸⁵Ibid.

⁸⁶Marc D. Schwartz, "Situation/Transition Groups: A Conceptualization and Review," American Journal of Orthopsychiatry 45:5 (October 1975), p. 747.

⁸⁷Encyclopedia of Social Work 16, Vol. 2, 1971, s.v. "Self-Help Groups," by Herbert Barish.

⁸⁸Marie Killilea, "Mutual Help Organizations: Interpretations in the Literature," in Support Systems and Mutual Help: Multidisciplinary Explorations, eds., Gerald Caplan and Marie Killilea (New York: Grune and Stratton, 1976).

⁸⁹Frank Riessman, "The 'Helper' Therapy Principle," Social Work 10:2 (April 1965), pp. 27-32.

⁹⁰Ibid.

⁹¹Caplan, op. cit., p. xi.

⁹²Ibid.

⁹³Christina Maslach and Ayala Pines, "The Burn-out Syndrome in Day Care Settings," Child Care Quarterly 6:2 (Summer 1977), p. 111; Pines and Kafry, pp. 499-507; and Coping With Cancer, p. 91.

⁹⁴Koocher, op. cit., p. 145.

⁹⁵Ibid.

⁹⁶Elwood R. Hamlin II and Elizabeth M. Timberlake, "Peer Group Supervision for Supervisors," Social Casework 63:2 (Feb. 1982), p. 83.

⁹⁷Tsuneko Apaka, Sidney Hirsch and Sylvia Kleidman, "Establishing Group Supervision in a Hospital Social Work Department," Social Work 12:4 (October 1967), p. 56.

⁹⁸Ibid., p. 58.

⁹⁹Petr Kropotkin, Mutual Aid: A Factor of Evolution (New York: Alfred A. Knopf, 1925).

¹⁰⁰Killilea, op. cit., pp. 41-66.

¹⁰¹Encyclopedia of Social Work 17, Vol. 2, 1977, s.v. "Self-Help Groups," by Alfred H. Katz, p. 1256.

¹⁰²Phyllis Silverman and Hope G. Murrow, "Mutual Help During Critical Role Transitions," Journal of Applied Behavioral Science, Special Issue: Self-Help Groups, eds., Morton A. Lieberman and Leonard D. Borman, July/August 1976, p. 41.

¹⁰³Alan Gartner and Frank Riessman, Self-Help in the Human Services (San Francisco: Jossey-Bass Publishing Co., 1977), p. 12.

¹⁰⁴Silverman and Murrow, op. cit., p. 411.

¹⁰⁵Leon H. Levy, "Self-Help Groups: Types and Psychological Processes," Journal of Applied Behavioral Science, Special Issue: Self-Help Groups, 12:3 (1976), p. 138.

¹⁰⁶Ibid.

¹⁰⁷Alan Gartner and Frank Riessman, Self-Help in the Human Services (San Francisco: Jossey-Bass Publishing Co., 1977), p. 117.

¹⁰⁸Marc D. Schwartz, op. cit., p. 747.

¹⁰⁹Gartner and Riessman, op. cit., p. 2.

¹¹⁰Ibid., p. 12.

¹¹¹Mark A. Kleiman, Joanne E. Mantell and Esther S. Alexander, "Collaboration and Its Discontents: The Perils of Partnership," Journal of Applied Behavioral Science 12:3 (1976), pp. 403-410.

¹¹²Gartner and Riessman, op. cit., pp. 79-80.

¹¹³Katz, op. cit., p. 435.

¹¹⁴Mildred Fine Kaplan and Anne Glenn, "Women and the Stress of Moving: A Self-Help Approach," Social Casework 59:7 (July 1978), pp. 434-446.

¹¹⁵Ibid., p. 435.

¹¹⁶Pierre M. Turquet, "Leadership: The Individual and the Group," in The Analysis of Groups, eds., Graham S. Gibbard, John J. Hartman and Richard D. Mann (San Francisco: Jossey-Bass Publishing Co., 1976), pp. 349-371.

¹¹⁷Ibid., p. 363.

¹¹⁸Ibid., p. 357.

¹¹⁹Ibid., p. 360.

¹²⁰Ibid., p. 352.

¹²¹Caplan, op. cit., p. 30.

¹²²Frances Peterson, "Teaching Undergraduate Social Work Students How to Help Others Maximize the Utilization of Social Welfare Resources in Bureaucratic Systems," (D.S.W. dissertation, City University of New York, 1978), p. 60.

¹²³David R. Beach, Murray Levine and Shepard Goldberg, "Teacher Discussion Groups: A Community Mental Health Approach," International Journal of Psychiatry 19 (Spring/Summer 1973), pp. 102-109.

¹²⁴Ibid., p. 102.

¹²⁵Ibid., p. 105.

¹²⁶Larry R. Bandoli, "Leaderless Support Groups in Child Protective Services," Social Work 22:2 (March 1977), pp. 150-151.

¹²⁷Ibid., p. 150.

¹²⁸Ibid., p. 151.

¹²⁹Ibid.

¹³⁰Kahn, op. cit., p. 62.

CHAPTER II

METHODOLOGY: PROGRAM DESIGN AND PLAN FOR IMPLEMENTATION

Introduction

This chapter describes the methodology of the project. It explains the nature of the research and the selection of a research design. The methods and findings of the needs assessment survey are reported and the implementation of the findings in the design of the group program is described.

The selection of a site for implementation of the project, the nature of the setting and characteristics of the sample group are described. The structure and focus of the program is reported and the range of methods for monitoring and data collection are documented.

Purpose of the Research

This was an exploratory study undertaken to provide information about an area of social work practice in which published work is scarce. Although training programs have been established to help staff learn important information and skills in relation to cancer, they have not included exploration of the potential con-

tribution of support to strengthen and consolidate the benefits of training.

In this project, a model program of peer support was designed and implemented, using data from a survey conducted to assess the need for such programs. The program of support was intended to enhance workers' ability to cope with the stress of their work with cancer patients.

The core of the project was the exploration of a worker problem and the evolution of a model to resolve it. As suggested by Carter and Wharf, the most appropriate evaluation framework for a program at such an initial stage and with a high degree of change and instability was not an outcome evaluation but a formative, ongoing process evaluation which "serves to refine the program design through frequent communication or feedback."¹

Descriptive or monitoring research, intended to describe what occurred rather than to explain it, was most appropriate for this project which sought to "collect information about a problem, a group or an organization and to explore issues and problems that occur in implementing new strategies."² In order to obtain data for a formative monitoring system, records of several kinds were maintained and, as recommended by Riecken, the actual operation of the program was recorded and is documented in Chapter III.³

For practical reasons, the model program could be implemented at only one site. While this does not provide a basis for comparison, the systematic monitoring of the program's progress yielded data which provide fuller information about how peer support would help social workers cope better with stresses of working with cancer patients.

Studies of an apparently similar phenomenon, worker burnout, recommend support programs for staff,⁴ although no systematic study has explored the components of such support or its potential impact on worker coping. In burnout studies there is the explicit or implicit assumption that improved worker coping will permit improved services to clients.⁵ This assumption underlies the present project which has as its ultimate goal the improvement of services to cancer patients. Measurement of this final effect is, however, beyond the scope of the project. Identification and measurement of more immediate effects were included and the study assessed the impact of the program of peer support, which constituted the independent variable, on the workers' ability to cope with stress, the dependent variable.

The Needs Assessment

A survey was conducted in 1980 to obtain specific information about the expressed needs and priorities of social workers involved in work with cancer patients.

The survey sought to determine the level and degree of stress experienced by social workers in their work with cancer patients and their means of coping with such stress. It also undertook to determine which aspects of any previous training had helped social workers to serve patients who face life-threatening illness and what support structures helped the workers to sustain educational gains and to cope with the stresses experienced in their work. The design of the model peer support program which was developed in the next phase of this study drew upon data regarding problems, needs and potential solutions identified by survey participants.

The Survey Instrument

The survey made use of a detailed questionnaire administered to a "purposive" sample of informants.⁶ This was considered to be the most effective way to generate information about issues on which little systematic work had been done.⁷ Both the investigator's experience in the cancer field and the review of related literature were used to formulate areas of inquiry in relation to the social worker's task in working with cancer patients as part of a mixed caseload.

The instrument employed was a self-administered questionnaire designed to collect data relating to workers' caseloads, coping systems, stresses and interest both in training and support. As no suitable standard-

ized instrument was found, an original questionnaire was constructed specifically for the survey's purposes. (See Appendix 1) The following issues were explored:

1. Social workers' perceptions of the nature of their work with cancer patients
2. Workers' attitudes towards the cancer patient case-load
3. The nature and degree of stress experienced
4. Ways in which workers cope
5. Existing support structures (including informal peer support)
6. Previous training specific to cancer (noting helpful aspects)
7. Teamwork and relationships with other staff
8. Availability of consultation

The questionnaire also sought to know workers' reactions to a potential program and asked for suggestions on these areas:

1. Types of program which would enhance worker coping
2. Forms of support structures which would be desired
3. Additional training desired

Survey respondents were provided with a clear set of instructions and the purpose of the survey was briefly described. Information was provided about the use of data and anonymity was assured. Although the intention was to collect as much relevant data as possible, efforts were made to limit the time needed for completion of the questionnaire to twenty-five minutes. Questions were both closed and open-ended, depending on the information

sought. For simple data, such as number of years of work with cancer patients, closed questions were used. For exploration of areas with limited previous information, open-ended questions were constructed.

A pilot test was conducted in order to refine the instrument. The respondents were briefed about the study and then asked to complete the questionnaire and comment on it. The instrument was modified to incorporate suggestions from respondents, eight of whom were social workers in a large, voluntary teaching hospital, all carrying mixed assignments which included cancer patients. Two additional respondents were acknowledged experts in the field; workers with many years of experience with cancer patients.

Administration of the Survey Instrument

The revised questionnaire was administered at five hospitals in the New York area. Two were voluntary teaching hospitals, one a state teaching hospital, one a large voluntary hospital and one a small community general hospital.

In each social work department, all MSW workers whose caseloads included cancer patients were invited to participate. The investigator briefed participants at each hospital about the survey prior to administration of the questionnaire. There were thirty-six respondents, drawn from varied assignments and with a wide range of

length of experience with cancer patients. In two of the five hospitals, 100% of those eligible by virtue of their assignments and having the MSW participated. In each of the remaining hospitals, more than 50% of those eligible participated. Since participation was voluntary, data relating to nonparticipants with similar case-loads were not available.

Because the survey sample was small and not randomly selected, findings were treated as "exploratory-descriptive."⁸ Since no major differences between hospitals were found, and since the number of respondents at some hospitals was low, all data are presented in aggregate form. By examining the aggregate data and by studying individual responses in depth, hypotheses were developed about the special problems of work with cancer patients as perceived by staff who undertake such work as part of their larger caseload.

Findings

In describing the findings, tables illustrating aspects of the total sample are presented and discussed. The respondents' perceptions of their work, its stresses and their means of coping are summarized and critical elements identified. Finally, needs in relation to support and training are reviewed and correlated with years of experience.

Work Experience of Respondents

Table 1 describes the work experience of the participants, illustrating the number of years worked in a hospital, the number of years post MSW and total and the number of years worked with cancer patients.

As demonstrated in the table, it is evident that a number of workers had pre-professional experience. The mean number of years of MSW work experience alone was 5.6, while the mean of total years in social work was 8.3. Similarly, the mean number of years MSW experience in hospitals was 5.4, but mean number of total years in hospital work was 6.5. Thus, it is clear that respondents had social work experience other than their work in hospitals, particularly non-MSW experience. The mean number of years worked with cancer patients was 5.5, indicating that many respondents also had previous noncancer-related experience in hospitals.

Number of Cancer Patients Seen Monthly

Nine workers (25%) reported seeing three or fewer cancer patients per month, nine saw between four and six, nine saw seven to ten and the other nine between 11 and 25 cancer patients monthly. With a range of one to 25 patients per month, the mean number seen was 8.5 and the median number 6.5. In no case did the cancer patients seen account for more than 75% of the total caseload of the worker. For sixteen workers (44%), cancer patients

TABLE 1
PARTICIPANTS' WORK EXPERIENCE (N=36)

Item	Frequency	Percentage
Years of MSW Experience		
2 or less	12	33
3 - 4	10	28
5 - 7	6	17
8 or more	8	22
Mean = 5.6 Median = 3.5 Range = .5 - 22 years		
Total Years of Experience		
2 or less	4	11
3 - 4	7	19
5 - 7	9	25
8 or more	16	44
Mean = 8.3 Median = 5.5 Range = 1 - 24 years		
Years Worked in Hospitals (post MSW)		
2 or less	14	39
3 - 4	9	25
5 - 8	6	17
9 or more	7	19
Mean = 5.4 Median = 4 Range = 1 - 21 years		
Total Years Worked in Hospitals		
2 or less	8	22
3 - 4	8	22
5 - 8	11	30
9 or more	9	25
Mean = 6.5 Median = 5 Range = 1 - 23 years		
Years Worked with Cancer Patients		
2 or less	10	28
3 - 4	9	25
5 - 7	9	25
8 - 22	8	22
Mean = 5.5 Median = 4 Range = 1 - 22 years		

made up less than 20% of total workload. For ten workers (28%), the percentage of patients with cancer was between 21 and 40 and for the remaining seven workers it was 41 to 75.

Criteria for Seeing Cancer Patients

Only 13 workers (36%) saw all cancer patients within their potential caseload. One did so because it was departmental policy; two did so as their own decision; for two all cancer patients were referred and for eight workers the decision was a combination of personal and departmental policy. For the workers who saw cancer patients on a more selective basis, criteria included the following: new diagnosis, age of the patient, the severity of the illness, patient difficulty in coping, discharge planning and time demands of the worker.

Problems of Cancer Patients

Thirty-two workers (89%) reported that cancer patients experience different problems from other patients. The other four workers (11%) felt that this was the case "at times." Respondents gave multiple explanations of such differences. The total of 56 responses included: physical (body image, disability, pain and treatment's side-effects); emotional (fear of death, anxiety, depression, anger, denial, loss of self-esteem and preconceived ideas); interpersonal (intrafamilial conflict and game-playing); and social (stigma and dis-

crimination). The most frequently stated response was fear of death, identified by 14 (39%) workers as a problem. One worker stated, for example, that the greatest problem was "fear of death on a daily basis."

Satisfaction from Work with Cancer Patients

Work with cancer patients was reported by 24 workers (67%) to be especially satisfying. Three (8%) stated that it was satisfying at times, while eight (22%) reported no special satisfactions, with one nonresponse. Responses identifying sources fell into two main categories: patient related and worker related. In the former category were the patients' ability to use help (cited by 17 or 47% workers), the patients' high level of need (eight or 22%), and patients' use of mutual aid (one worker).

Worker related factors were: long-term relationships (three workers), and interest in coping behavior (two workers). One worker noted that gains in medical treatment for cancer brought satisfaction. Only two workers reported reasons for not finding cancer work specially satisfying, citing the patient's denial and refusal of treatment and disappointment that anticipation of great satisfaction was not fulfilled.

The responses indicated that the majority of workers felt that the patient's response to help offered was the critical factor in experiencing satisfaction.

As one stated, "the intensity of feelings often makes the patient more receptive to social work and gives the worker the feeling of being needed."

Stress Involved in Work with Cancer Patients

Thirty-five respondents (97%) stated that work with cancer patients was especially stressful; the remaining worker said that it would be if it were the only assignment. Stress factors fell into three categories, related to the client, the disease or the worker. Client related factors were anger, denial and pre-mourning. Disease related factors were pain and suffering, disfiguration and the palliative nature of treatment. Worker related stressors were the majority responses and included identification and fear as well as personal experiences; concern with death and dying; feelings of loss; workload; the uniqueness of the social work role; minimal community support and lack of experience.

Outstanding stressors for the worker were identification with the patient, fear of the illness and fear of death. One worker stated that: "it is difficult and painful to watch deterioration and eventual death." Such responses, all concerned with the expectation that cancer will cause death and the fears of the workers, made up 15 of the total 48 responses (31%).

Aids to Coping With the Work

Respondents were asked to identify aids to coping both on the job and outside work. In regard to the former, two categories emerged from the responses, those related to the personal coping mechanisms of the worker and those coming from the job structure. In the personal coping category were: denial, humor, education, satisfaction and withdrawal. Responses noted as based on job structure were: supervision, time off, mixed caseloads, team and peer support and realistic goals. An example was: "...my supervisor who is very supportive and who has worked with many cancer patients."

Responses related to job structure were stated most frequently. Among the 57 responses noted as aiding coping, team and peer support were referred to by 44 workers (79%). Aids to coping outside the workplace were grouped into three categories: relationships (friends, families and therapy), emotional or intellectual outlets (denial, separating and thinking through) and activities such as sports and artistic endeavors. Of a total 49 responses, 25 (51%) related to relationships, seven (9%) to emotional/intellectual outlets and 17 (35%) to activities.

Sources of Support

The most important sources of support were peers and other staff. Some workers referred only to "peers,"

"team" or "staff," while others referred to two or more of those sources. It was not clear whether "peers" referred only to social workers or included other disciplines; similarly with "staff." Therefore, these apparently overlapping categories were combined, providing a total of thirty-nine responses. While the data did not permit further breakdown of this category, it seemed clear that the most important source of support for social workers was in their relationships to other staff of the hospital. No groups or formal channels, such as peer supervision, were mentioned, suggesting that such support was derived on an informal, as-needed basis. Next in importance was supervision, a source to which sixteen workers reported turning for support. Other sources identified were family and friends (eight workers), reading and seminars (three workers), and therapy (two workers). One worker used the recently formed oncology network for support.⁹ Another stated that there was no support at all.

Value of Support

Workers' responses to the question of frequency of discussion of their work with colleagues suggested that those seen as most helpful were team members who also knew the patients. Only 12 (33%) workers reported that they usually or often discussed work with other social workers, while 22 workers (61%) usually or often

held such discussions with other hospital colleagues. Since more workers would discuss their work with social workers than other colleagues "sometimes," the data suggested that both sources of colleague support were well used, with somewhat more emphasis on team members than peers in the social work department.

Resources for discussion outside the hospital were almost exclusively reported to be family and friends. Twenty-seven workers reported that discussion of their work was helpful. The remaining nine (25%) workers all stated that it was sometimes helpful. It was said to provide a "shared experience" (13 workers), "relief" (11 workers), and "understanding" (9 workers). Eight workers (22%) reported finding few willing listeners.

Preference for a Cancer Assignment

Thirty workers (83%) reported that they would not prefer a client population which excluded cancer, three (8%) reported that they would prefer such a change, while two (6%) would "at times," and one did not respond.

Reasons cited for preferring the current assignment included the special nature of the work, noncancer-related reasons and the existence of a mixed caseload. Only nine workers (25%) were prepared to accept an all cancer assignment; one would do so with increased skills; three were unsure and 23 workers (64%) were not willing to do so.

Reasons cited for reluctance to take on an all-cancer load were similar to factors noted as stressors in work with cancer patients, namely depression, identification with patients and the equation of cancer with dying. Nine (25%) workers stated a preference for a mixed assignment. Sixteen (44%) thought that an exclusively cancer assignment would be depressing or simply stressful. For those willing to risk such an assignment, the reasons cited were: the valuable nature of the work, previous positive experiences and opportunities to learn.

Activities Related to Dying Patients

Data reported in relation to stresses for patients and staff suggested that the popular notion of cancer equating a death threat made the disease very frightening to both clients and workers.

TABLE 2
PROPORTIONS OF DEATHS IN CASELOAD (N=36)

Percentage of Deaths	Frequency
Up to 10%	12
11 - 30%	8
31 - 70%	7
71 - 100%	6
Cannot Estimate	3

Table 2 illustrates the actual proportion of deaths within the workers' caseloads, according to their

own estimates. It is of note that although concern with death was a major issue in worker stress and in patients' problems, 12 workers (33%) reported that 10% or fewer of their patients died during the time they worked with them. (No data were available about the death of patients soon after discharge or transfer.)

When patients died, 31 workers (86%) reported offering services to the family. For example, a pediatrics worker stated: "call to offer condolences and ask if they would like to come in and talk or would like a referral to a group of bereaved parents." Another stated: "contact with patient's family and offer my help and support." Only two workers reported that they undertook no activity with bereaved families. Three workers, one of whom had not yet experienced a client death, did not answer questions related to dealing with families and with the workers' own feelings.

There was a total of 50 responses related to how workers deal with their own feelings. (Many workers gave multiple responses.) Nineteen workers (54%) reported discussing feelings with others. For example, "talk about patient with medical and nursing staff who are also experiencing the loss. Share feelings with a close friend who is also a social worker." Sixteen workers (44%) referred to feelings of sadness or loss, such as: "will often feel sad if I've been very involved" and "think about patient's qualities and the circumstances of death."

Grieve a little. Wonder why people suffer illness and pain." There were also attempts to deny feelings: "sometimes I try to deny what may be strong feelings, but I try to share them with colleagues." Or, in other cases: "suppress them," or "try not to get too upset." Five workers (15%) referred to feelings of relief, such as, "a feeling of relief especially if the patient has been under a great deal of stress and pain." One worker described withdrawing from other patients as a result of her feelings about death.

Training

Nine workers (25%) had some training for work with cancer patients, such as courses on death and dying or seminars on cancer. Most were courses of short duration. Another eight workers (22%) had no training but had attended a single workshop or conference related to cancer or thanatology. Nineteen (53%) had no such experience.

Twenty-seven (75%) would like further specialized training for their work with cancer patients; three were unsure; three did not want it at the time and three wanted no further training. Those who did not want training cited among their reasons: other interests, already having a strong background or not yet having enough work experience to benefit. For example, "as much as I feel my work with cancer patients is very important and satis-

fyng to me, my own career interests are in other areas which I would like to pursue further."

For those desiring training, topics of interest included death and dying, loss, medical information and coping with stress. The range of modalities suggested included seminars, workshops, and groups.

Workers' Need for Support

Workers were asked whether client characteristics, stage of the disease or other factors contributed to a need for support for the worker. Among 39 responses which related to client's characteristics, there were thirteen references (33%) to resistance or denial by the patient. Youth of the patient was mentioned nine times and anger or acting-out eight times. Less frequently cited characteristics of the clients were: disfigurement, odor, pain, isolation, depression, family avoidance or guilt and dependence.

Since cancer, as a chronic illness, goes through several distinct phases, workers were asked about the significance of the stage of disease (including newly diagnosed; remission; recurrence/metastases; and terminal care). The terminal stage was the predominant response: 20 of 32 (63%). New diagnosis was next most frequently cited (nine times), with mid-stage and metastases referred to only three times. Other responses related to the workers' need for support were: new clients, inter-

professional stress, lack of concrete supports and identification with the patient (six references).

Interest in Additional Support

Twenty-four workers (66%) expressed interest in additional support. Six were not interested, and an equal number were "possibly" interested.

Potential sources of support suggested by respondents included peer groups, consultation, supervision, other professionals and seminars. There was some overlap between categories since workers cited more than one resource, but it was clear that the major sources of support perceived by workers were peer groups (20 workers) and consultation (15 workers).

TABLE 3

INTEREST IN SUPPORT BY YEARS OF SOCIAL WORK EXPERIENCE (N=36)

	Years of Experience in Social Work		
	Low	High	Totals
INTEREST IN SUPPORT			
	No		
	1 (9%)	12 (48%)	13 (36%)
Yes	10 (91%)	13 (52%)	23 (64%)
	11 (100%)	25 (100%)	36 (100%)

Low = 0 - 4 years

High = 5 years or more

TABLE 4
INTEREST IN SUPPORT BY YEARS OF EXPERIENCE
WITH CANCER PATIENTS (N=36)

	Years of Experience With Cancer Patients		
	Low	High	Totals
INTEREST IN SUPPORT			
No	4 (21%)	9 (53%)	13 (46%)
Yes	15 (79%)	8 (47%)	23 (64%)
	19 (100%)	17 (100%)	36 (100%)

Low = 0 - 4 years
High = 5 years or more

Tables 3 and 4 illustrate the cross-tabulation of experience, both in social work and specifically in work with cancer patients, with interest in further support. They show that workers with few years of experience in social work or in work with cancer patients expressed considerably more interest in support than did workers with many years of experience. Review of the responses of less experienced workers supported this inference. Several demonstrated their enthusiasm for the idea of development of other supports by underlining a "yes" response or adding one or more exclamation points.

Table 5 illustrates the cross-tabulation of age and interest in support. Of the four respondents under 30 years old who did not express interest in support, it

TABLE 5
INTEREST IN SUPPORT BY AGE (N=35)

INTEREST IN SUPPORT		Age		Totals
		Up to 29 Years	30 and Over	
INTEREST IN SUPPORT	No	4 (36%)	9 (37%)	13 (37%)
	Yes	7 (64%)	15 (63%)	22 (63%)
		11 (100%)	24 (100%)	35 (100%)

is notable that three had five years or more experience in work with cancer patients.

Preliminary review of the findings indicated that newer workers experienced more stress in their work with cancer patients. This judgment is based on the fact that they expressed more interest in support programs than their more experienced colleagues. This finding might indicate that over several years of experience, and as a direct result of the work situation, the worker developed more protective coping devices. However, in a study which discusses age-related difficulties experienced by students in work with the terminally ill, it is suggested that young professional students may perform competently but "with considerable pain."¹⁰ In the study, students 30 years of age and older showed ability to use formal educational supports, to integrate their experiences more

readily and to reduce their anxiety to manageable proportions.¹¹ In seeking to explain these observations, Caroff and Vigilante draw upon developmental theory and noted the younger students' struggle to master skills "both to understand and intervene in precisely those areas which are intrinsic in their normal ongoing developmental struggles."¹² The older student has achieved greater personality consolidation, has usually experienced more loss and recovery and, as a consequence, is "more ready developmentally to use the sensitivity to self as a springboard to the understanding of the pain of this client."¹³

These findings suggested the possibility that the present study's inverse correlation between years of experience and desire for greater support might reflect needs felt by workers as a consequence of youth rather than limited professional experience.

Table 6 presents the effects of age as an intervening variable. It illustrates that more workers were interested in support than not interested, in both age groups. Those with low experience in the higher age grouping tended to be interested in support (8 of 11) though workers with high experience also showed some interest (7 of 13). In the younger group, however, those with interest in support were predominantly only those low in years of experience. Where young workers had high experience with cancer patients, they did not express

TABLE 6

INTEREST IN SUPPORT BY EXPERIENCE WITH
CANCER PATIENTS AND WITH AGE AS AN
INTERVENING VARIABLE (N=36)

	Age Up to 29		Age 30 and Over		Totals
	Low Experience	High Experience	Low Experience	High Experience	
INTEREST IN SUPPORT No	1 (14%)	3 (75%)	3 (27%)	6 (46%)	13
Yes	6 (86%)	1 (25%)	8 (73%)	7 (54%)	22
Total:	7 (100%)	4 (100%)	11 (100%)	13 (100%)	35

Low Experience = 0 - 4 years

High Experience = 5 years or more

interest in support. This suggests that years of experience may be of greater significance than age in motivating workers to seek support systems or that years of experience may interact with age to influence such interest.

General Comments About Cancer Work,
Its Stresses and Coping

Some dominant themes were evident in the statements of the 23 (64%) respondents who commented on the effects of their work on their lives, both professionally and personally. Several workers referred to changes in their coping over a period of time. As beginning workers they had experienced difficulty dealing with the illness and death of their clients but, after gaining experience,

they had developed various means of coping, including detachment. One worker expressed concern about this as follows: "Am I now becoming so detached I don't care?"

Dealing with death and its threat emerged as a point of great stress--an emotional burden, work that could not be done as the sole assignment. One worker reported that the deaths of some patients had been extremely painful to her but that she "had been able to move on, as one must."

Workers at different hospitals concurred that it was more difficult to work with defenses and feelings of team members than with those of patients. As an example, one worker described a doctor who used a telephone call to discharge to a terminal care home a patient he had known for some time.

Workers described in several different ways the major impact of the work on their lives. They identified a sense of vulnerability and its effect in making life seem more precious. One worker referred to taking less for granted, another felt the need to work with dying people in order "to fully appreciate the importance of life." Workers wrote of becoming more in touch with their own mortality and of experiencing their greatest gratification, fears and motivation in this work.

The interrelationship of personal and professional concerns was seen in some workers' concern to "think about and treat myself positively," and the observation of an-

other that "it was hard to give to others when I needed it too," after experiencing a death in the family.

The general comments highlight many of the themes and issues which emerged from responses to structured questions of the survey. They suggested that social workers felt many stresses in their work with cancer patients, that such stresses were carried over into personal as well as professional lives, that work with cancer patients was experienced as a positive challenge as well as a stress, and that workers strived to develop means of coping that did not involve emotional withdrawal from their clients.

Implications of the Findings for the Program Design

Although the small non-random sample limited the extent to which the findings could be generalized, some important propositions emerged from the needs assessment. Firstly, the findings supported the proposition that the emotional impact of cancer causes particular job stresses for social workers serving cancer patients. Nevertheless, most workers surveyed preferred to retain assignments that included cancer patients, since they experienced satisfactions as well as stress. There was evidence that ways of coping with such job stresses were many and varied including, on the one hand, use of team and peer support and, on the other, denial and withdrawal from clients. Thus, the findings suggested that some coping

means were not in the best interests of the clients, although the potential for more successful coping was demonstrated by some workers.

The findings lent support to the view that a structured program of peer support would enable workers to cope more effectively with stresses arising from their work with cancer patients. Peers and professional colleagues were both the major sources of support cited by workers and the primary potential sources of support suggested. A majority of workers expressed interest in both further support structures and specialized training. These findings were incorporated into the design of the peer support program. They supported the decision to develop a program which would enable workers to expand and enhance their range of coping methods. Since peers were perceived as good potential sources of support, the design focused on testing a model of peer support within a single social work department in which colleagues could develop mutual aid.

While some workers with many years of experience in social work and in work with cancer patients were also interested, it was the less experienced workers and to a lesser degree the younger workers, who seemed particularly eager for more training and support. The anticipation that such workers would be the most likely participants led to inclusion of a training component in the design of the program. The specific focus of such training was

difficult to plan. A very diverse group of stresses was identified in the survey, including concerns related to death, uncertain prognosis, hopelessness, pain, denial, and lack of community support among many problem areas cited. This diversity, together with the satisfaction of the work, suggested that the specific training needs of a particular group of workers within one social work department would be determined through their participation. As proposed by Knowles, the program design therefore left room for the participants to become active in deciding its specific focus, using their range of experiences and needs as the basis for selection of content.¹⁴

Selection of a Site for Implementation

The site chosen for implementation of the project was one of the five hospitals which had participated in the needs survey. It was considered very important that the administration of the department chosen for implementation of the model give full sanction to group participants to attend regularly and on work time, although on a voluntary basis.¹⁵

At East End Hospital¹⁶ there were several advantages for implementation. A well-established and well-regarded social work department offered a large potential pool of participants with appropriate professional qualifications and interest. This was the hospital at which

the greatest initial interest had been shown, with fifteen members of staff responding to the needs survey.¹⁷

As a large, voluntary teaching hospital, it offered treatment to many cancer patients at all stages of the illness. There was no worker assigned exclusively to a cancer service and none was designated as an oncology worker.¹⁸ This increased the chance that there were common needs for support on the part of all potential program participants, since no worker received special support from an interdisciplinary oncology team. The department had previously arranged a brief educational program related to cancer but had never planned a support structure specifically in that area, so that the felt need of staff for help in relation to the study's focus was high.¹⁹

The administrators of the department were eager to promote staff interest in research. Although some staff members had published articles related to research and practice in the health field, most workers were not involved in research activities. The administrators were, therefore, favorably disposed towards this research, in which staff could participate and from which they would derive enhanced skills.

The investigator's professional connections with an administrator of the department had also formed a base of mutual trust and understanding.²⁰ The department was, therefore, ready to establish the program as one of two

staff development programs for the year, publicizing it and encouraging staff participation. The group program offered a staff development program without a consultant's fee, which may have further motivated the administration to cooperate with the investigator's research interests.

Description of the Setting

The East End Hospital is a large, voluntary teaching hospital on the East Side of Manhattan, and offers a diverse population both in-patient and ambulatory services. As a general hospital, offering acute care to both adults and children, it provides a wide variety of clinical services and includes a range of treatments for cancer patients. It is a highly respected institution, supported by numerous benefactors, and able to provide excellent facilities for patient care. This is the teaching hospital of a large university medical school and some of the staff of the social work department hold academic appointments in the medical school.

The social work department has a staff of 43 workers, of whom 29 hold Master's degrees.²¹ Offices are in various locations, many close to the area of their assignments, but others remote from any patient contact. There is no centralized group of social work offices. Building renovation caused office disruptions such that staff had to enter one area through a parking garage and refuse area. Newly available and superior office space

is offered on the basis of seniority of tenure, with the result that the most junior members of the staff may be located in the most isolated offices, far from potential sources of support such as peers, supervisors and colleagues from medicine and nursing.

Although there is no union organization in this department, salaries are high because such hospitals seek to match or better union-negotiated salaries elsewhere and to avert the possibility of unionization.²² (Salaries for social workers in hospitals are generally high relative to those of workers in public welfare and non-medical voluntary agencies.) A highly competitive salary range may be a contributing factor in the notable stability of this department where staff turnover averages only two per year. Some staff have worked there for more than twenty years. There are also recent graduates on staff, some of whom have been working for less than two years. This is the first job for a high proportion of the staff. Most of the staff are female, including the administrators and supervisors.²³

The department is well-organized and has professional systems of accountability such as written policies and procedures, a case-finding system, a peer review mechanism (which examines written records of patient contacts) and educational programs including graduate student field placements from several schools of social work. As in many similar hospitals, social workers have

the right to offer services to all patients and are not dependent on medical referrals. Despite the value of this policy for the professional autonomy of the department, it is not acted on in situations where collaboration with physicians would be compromised. Thus, in some areas, referral from physicians will be sought prior to entry to a case. A high proportion of cases are identified in team meetings involving nurses and doctors. Cases are accepted on referral and are selected because they meet high-risk criteria for social/emotional problems. In some areas, such as the kidney unit, all patients are seen by social workers. In ambulatory services, only those referred by team members or requesting services are seen. The primary practice method employed by the social workers is individual casework. Some work involves family members and there are a few group services.

Social workers are encouraged to take advantage of educational opportunities throughout the institution, such as lectures and grand rounds. Continuing education is encouraged by the provision of tuition reimbursement. As workers acquire seniority they are expected to practice fairly independently, receiving consultation from a supervisor instead of the more structured supervision given to workers in their first years in the job.

The climate of independence is also associated with a degree of isolation of workers one from the other.

Staff meetings are held regularly but are essentially administrative, focusing on an agenda prepared by the administrative staff of the department. There is a limited history of group supervision or group support. One staff group, led by a psychiatrist, was established with the goal of helping staff examine their attitudes to working with groups. The group experience focused mostly on issues of worker morale and served as a vehicle for staff getting together and asking for some changes in the administrative practices of the department. This was regarded by the administration as a productive outcome although no additions had been made to the group program for clients.

The investigator's understanding of the nature and characteristics of the department was developed from several sources. First, was the reputation of the department in the professional community with which the investigator was already familiar. Second, was the series of planning discussions held with the Associate Director of the department. Once the program was agreed upon in principle, there were additional meetings which included an administrative supervisor of the department. While other investigators have highlighted the importance of obtaining endorsement and sanction from the power structure of the site involved,²⁴ gaining admittance to the setting in this way could present difficulties. For

example, there is an inherent strain between the goals of the investigator and those of the departmental administrators. For the purposes of research, the investigator seeks to learn all that can be known about the department which might have bearing on the research topic. This may cause discomfort for administrators who, understandably, would like to present their program in the most favorable light. In Boys in White, it is noted that the researcher's questions and pursuit of information may appear as a criticism to those deeply involved in the organization. The views of the organization of lower level personnel may not coincide with those of the administrators.

There is no organization in which things look the same from all positions. There is none in which aspirations and realities are identical. To point out disparities in any particular institution may appear to those most concerned both an exaggeration and a criticism.²⁵

In establishing this program, all initial information about the setting was provided by the administrators. The investigator's knowledge and understanding of the setting was later amplified by information provided by program participants and by direct observation. While no major discrepancies were revealed, there were differences in perceptions of the department's culture and its program which emerged as the perspectives of workers at different levels within the organization were understood. Such differences, and the concern that they

might cast a negative light on the program, may cause administrators to hesitate to allow investigators to meet freely with staff and document their ideas and views. In the case of East End Hospital, the administrators of the department gave basic descriptive data and gave sanction to the investigator's study. Although they expressed interest in knowing the outcome of the study, it was agreed that there would be no direct feedback of information about the support and training group from the investigator to the department's administration. This was considered important because the study would then have a degree of independence from the social work department, being sanctioned by it but not accountable to the administrators for particular outcome goals. Furthermore, it would provide confidentiality for the program participants, leaving them free to explore issues and concerns that they might hesitate to discuss with their administrators. The separation of the study from the department's administration was in part accomplished because of the pre-existing relationship of the investigator to the Associate Director of the department. It was also due to a commitment to research in the field and a real interest in the staff's development of peer support on the part of the administration.

The initial need to secure sanction from the administrators has the consequence that a study may be identified as part of the administrative structure of the

department. In this case, the investigator was presented to staff by their administrator as a member of the faculty of Columbia University School of Social Work, so that the expectation was that the investigator would be seen as a teacher rather than an administrative adjunct. The faculty role was reinforced by the recent experiences of some members of the staff with the investigator as their faculty field advisor for students placed in the department.

The relationship of a participant observer to the study group is difficult and complex.²⁶ In this study the investigator acted as the facilitator of the support and training group and as such was required to strive for the difficult combination of the development of rapport with the participants and the maintenance of sufficient objectivity to further the study's goals of systematic data collection.²⁷ Thus, in planning the model program it was essential for the investigator to keep in mind that there would be reactive effects to the researcher's presence, distortions in observations, limitations on what could be witnessed, and the need to be vigilant in order to minimize such limitations as they occurred.²⁸

From the point of entry into the setting, it was important to make clear the investigator's intent and goals for the model program. This not only helped to obtain sanction at the site, but was an essential element in gaining acceptance from the study participants.

Whyte has described the possibility of obtaining the workers' confidence by demonstrating hostility to those in management positions, pointing out that even in conflict situations a skillful researcher can establish an independent position.²⁹

Professional ethics and the investigator's intentions precluded taking sides on departmental issues. The setting was selected because it was regarded as rather traditional, insofar as it had a hierarchical administrative structure and style, and because it offered stability and the absence of any known conflict which might have interfered with the study's purposes or the participants' ability to involve themselves in the group program. The investigator explained to the participants the study's goals and the researcher's role and responsibilities within the setting, making it clear that findings would not be reported to the administrators and that all material included in the study report would conceal identities.

Selection of the Sample

The group size was planned as eight to ten MSW workers. The size selected was based on the nature of the program: as a group for mutual aid, it would have common elements of both therapeutic and training groups. The literature on such groups suggests that diverse factors influence optimal group size. Turquet states that

"a membership of twelve seems to be getting near the upper limit of a single member's capacity to encompass and take in, with sixteen as the extreme limit."³⁰ He points out, however, that "at the other extreme, if membership numbers are five or six, again phenomena of a different order appear -- phenomena more directly related to the field of family dynamics and family fantasies."³¹

In restricting participation to those with a Master's degree, it was assumed that all members would thereby share a common base of training and background knowledge, despite varied professional experiences. Attendance at the program was voluntary but members were expected to continue in the group throughout the period of the study. Although all were engaged in direct work with cancer patients, two members of the group carried complex assignments as both direct service workers and supervisors. The presence within the group of both supervisors and their supervisees was anticipated to be a factor adding complexity to the group's potential for the development of mutual aid.³²

Description of the Sample Group

Age

Ten self-selected workers participated, nine female and one male. Their ages ranged from 27 to 61 years, with a mean age of 38 and a median age of 32.5. When compared to the ages of survey respondents which

ranged from 23 to 59 years, with a mean age of 36 and a median age of 34, it is seen that both range and mean ages are similar but with members of the sample group on average slightly older than the survey respondents.

Motivation for the Program

The investigator sought to clarify reasons for participation. Information was collected by questionnaire and, prior to the program, an administrator who coordinated the group's selection identified the following motivating forces:

1. Desire to learn
2. Desire for a place to express anxieties
3. Positive experience of a previous group (especially in relation to increased familiarity with other workers' assignments)
4. Lack of any formal support structure in the department

Six workers reported themselves to be very interested, three were fairly interested and one only slightly interested, but none would have preferred not to participate. This suggests that participation was in fact, as well as intent, voluntary, although the extent of encouragement and incentive given by administrators was not known.

Experience Histories

Table 7 describes the work experiences of the participants, illustrating the number of years of MSW

TABLE 7
PARTICIPANTS' WORK EXPERIENCE
(N=10)

Item	Frequency	Percentage
Years of MSW Experience		
2 or less	3	30
3 - 4	2	20
5 - 7	0	
8 or more	5	50
Mean = 8.9 Median = 6 Range = 1 - 22 years		
Total Years of Experience		
2 or less	1	10
3 - 4	2	20
5 - 7	2	20
8 or more	5	50
Mean = 10.6 Median = 9 Range = 1 - 24 years		
Years at East End Hospital		
2 or less	3	30
3 - 5	1	10
6 - 10	3	30
11 - 20	3	30
Mean = 8.2 Median = 7 Range = 1 - 19 years		
Years Worked With Cancer Patients		
2 or less	1	10
3 - 4	2	20
5 - 9	3	30
10 - 14	2	20
15 - 20	1	10
NA	1	10
Mean = 7.6 Median = 7 Range = 2 - 20 years		

experience, the number of years in social work, the number of years at East End Hospital and the number of years worked with cancer patients.

As the table illustrates, since none of the workers had more than five years experience prior to the MSW, the difference between average number of years of MSW experience and total years of experience is less than two.

Although some members had been in the field only two or three years, the average level of the group is high. When the mean and median numbers of years of experience, both pre-MSW and total, are compared to those of the larger group surveyed in the needs assessment, this group is seen to have more years of experience in the field.

The relatively small difference between the average number of years worked in social work and the average at the hospital demonstrates that for many members of the sample group the present job is the only, or major, professional experience.

The mean and median number of years of cancer experience are slightly lower than those for years at the hospital and in social work. The small difference suggests that most workers have worked with cancer patients for the greater part of their careers.

When the mean and median years of experience at the hospital are compared to those for years of experience at any hospital, as reported by respondents to the needs survey, the finding that this group is relatively experienced is confirmed. Similarly, the number of years

of experience specifically with cancer patients is higher in the sample group than in the survey, as reflected in higher mean and median numbers of years. Thus, the sample may be seen as a group of relatively experienced workers, with those very new to the field in the minority.

The mean percentage of the workers' total case-loads composed of cancer patients was 46 and the median 50. These percentages are slightly higher than those for the survey population, and the range of 10 to 85% of all cases for the group members indicates that all members of the group saw more cancer patients than the eight (22%) workers in the survey who reported less than ten percent of cancer patients per month in their caseload. Similarly, actual numbers of cancer patients were slightly higher for the group than for the survey population.

Job Stability

The study sample was drawn from a social work department with generally infrequent turnover of personnel, but specific data were sought on the sample group's expectations for future professional activity. Literature on burnout suggests that workers who cannot adjust to stressful jobs or who do not identify with their profession may leave.³³ Data collected related to commitment to current assignments, including the cancer component.

Five years into the future, three workers would still expect to be working at East End Hospital. Of the others, one anticipated retirement and six expected to move into other positions in social work.

The data indicated that most workers who expected to leave the present job planned to continue working in client-focused positions, one of them specifically with the terminally ill. Thus, the data suggested strong commitment to the profession.

Training and Professional Stimulation

Nine workers reported some professional training since the MSW degree. The remaining worker had attended workshops and conferences. Some of the courses identified were of short duration and more like workshops. The topics covered a wide range, with an emphasis on supervision. Also cited were courses on death and dying, chronic illness, bereavement and cancer.

All ten workers were state certified and eight were members of NASW. Of those, three had obtained the ACSW. Workers also held memberships in the Association of Pediatric Oncology Social Workers, the Oncology Network, The Association of Clinical Social Workers and Orthopsychiatry. Only the newest worker, who had been in the field less than one year, belonged to no professional organization. Sources of professional stimulation were reported primarily as colleagues at the hospital, al-

though other professional colleagues, supervision and reading were noted almost as frequently.

Preference for a Cancer Assignment

Although one worker would prefer a different client population and another would "sometimes," eight workers prefer their current assignments. Reasons cited were not unlike those noted in the needs survey, and included both the variety of the assignments and the rewards of work with cancer patients. Reasons for preferring a change were the depressing and unpleasant aspects of working with death.

Four workers would not accept an exclusively cancer assignment and a fifth would not but noted, "maybe in the future." Only three workers would accept such an assignment and one would in a hospice environment. One worker expressed uncertainty but made comments which indicated real doubts about ability to work in an exclusively cancer related job.

Knowledge About Cancer

Six workers reported that they felt knowledgeable about cancer, three felt fairly knowledgeable and one was guarded. Having knowledge of the disease did not preclude wanting more, and eight workers expressed interest in having more information. Some specific topics of interest were medical information, the nature of the

emotional stress on patients and skills for helping patients and families to cope.

Involvement in the Job

Six workers reported that their work with cancer patients called for much more intense involvement than work with others. Two workers thought that it called for slightly more involvement and two that it was about the same. No one reported less involvement.

Five workers reported themselves to be moderately involved in their jobs and the other five reported themselves to be strongly involved. None felt only slight involvement. Social activity with other social workers after work was reported as occasional by seven workers and frequent by one. Two workers did not meet with other social workers for any social activity.

Social Relationships

Social relationships between members of the group were varied. Because it is a large department and because social work offices are not located in a single area, some members of the group knew each other very slightly. They met only at formal staff meetings or by chance. Other relationships were structured by the administrative plan of the department. Two workers in the group supervised four other members. These relationships were reported matter-of-factly when initial data were collected. During the course of the program, the effects

of the mix of supervisors and supervisees was discussed. The relationships seemed quite relaxed, with a minimum of strain affecting the workers' ability to work together in the group. Some instances in which such strains appeared are cited in the discussion of the group's progress and themes in Chapter III.

The critical factor which prevented the supervisory relationships from interfering greatly with the group's activities was that the supervisors themselves were also direct service workers. They carried caseloads similar to those of their supervisees and, by virtue of their common struggle with feelings about cancer, they identified themselves, and were identified by their staff and the other workers present, as peers and colleagues. It was stated in the group that a supervisor who did not share client responsibilities would have been perceived very differently.

Some workers had come to know each other well because of long tenure in the department, others worked in close proximity and three workers reported close friendships with other members of the group.

Assignments

Services covered in the workers' assignments were quite diverse. For the most part, all those assigned to adult services, whether private, in-patient, out-patient, medical or surgical, seemed to have some knowledge of

each other as colleagues and some limited familiarity with each other's work. Detailed knowledge existed only between supervisors and supervisees or close friends. The workers assigned to pediatrics and Obs/Gyn knew little of the work of other members of the group and were little known. Their experiences, rarely meeting other members of the group in the course of their work, stimulated considerable discussion of the relative independence and isolation of social workers throughout the department.

The Group Program

A program of peer group mutual support was established with the investigator as its leader/facilitator. The program's content and focus incorporated the suggestions of respondents to the needs survey but was also open to modification as participants identified needs previously unrecognized, or found others readily met. The major focus of the program was the development of a mutual aid support group. The study documented and explored that process, locating themes and turning points in the process as these were expressed in discussion topics, levels of participation, revelation of negative feelings towards work with cancer patients, pursuit of new knowledge and instances of mutual aid and exchange of ideas.

There were eight planned group meetings of one and one half hours. The program began on October 15, 1981 and terminated on December 10, 1981. A follow-up meeting to assess progress and to review programmatic effects was planned. At the request of the members, the program was also extended by one session which was held on January 14, 1982. The group met at a regular time and place and attendance was voluntary, although during regular work hours and with administrative sanction. The follow-up meeting was held two months later in order to allow the impact of the program to be consolidated. Since the group continued to meet after the program terminated, holding lunch-time meetings every other week, the investigator attended two sessions as follow-up meetings on March 11 and March 25, 1982. At the meetings, the impact of the program was reviewed and data were gathered about the program's continuation as a leaderless group for support. These data are discussed in Chapter III.

Data Collection

In the program phase of the study, which used the findings of the needs assessment to design a model program to provide support and training, primary emphasis was given to a formative evaluation. Survey data were incorporated into the development of the support group and monitoring procedures included self-reports of participants, logs of observations of the investigator, tape

recordings of each session, attendance records and individual interviews with participants. Other effects of the program were identified through unsolicited feedback from participants, their colleagues and others. In a limited attempt to assess outcome, participants were questioned before and after the program to evaluate changes in their feelings, attitudes and coping behavior related to the stress of their work with cancer patients.

In addition to generating information on the process of establishing the support group and its progress, the study measured changes on selected variables. Key variables were derived from the propositions of the study and from the data collected and analyzed in the needs assessment phase. The variables included job stresses, feelings, attitudes and coping. Feelings explored included distress, competence, success, helplessness, exhaustion and a wish to withdraw. Attitudes explored included job satisfaction, preference for cancer patients and interest in learning about cancer. Coping, another key variable, was defined as the behavior of workers responding to stressful work. Self-reported coping behavior included engaging in direct contact with patients, relating to other workers and seeking information with regard to cancer patients. The variables selected to define stress and coping were measured by self-reports of participants on questionnaires administered before and after implementation of the support program.

Monitoring Devices

Measures of the program's actual contact with participants were captured in records of the frequency of meetings, attendance records and monitoring procedures to examine the content of group discussions. (See Appendix 3 for attendance records.)

The extent of participation was assessed by review of the tape recordings of each session of the program and was supplemented by review of the log maintained by the investigator. (See Appendix 9.) The log, written directly after each session, captured highlights of the group's atmosphere, including lateness of arrivals, interruptions by telephone calls, changes of seating arrangements, etc. It also documented the personal experience of the investigator as the leader/facilitator of the group and amplified the taped records of the group's transitions and development over time.

Turquet points out that in the role of observer of the group, a leader experiences situations when the evidence available "as to the state of the group's health will be his own personal experience of the group, what he feels the group is doing to him, and how he feels the group inside himself."³⁴ The group process is reviewed and analyzed in the next chapter.

Attendance records were supplemented by a seating chart of each session, maintained in order to capture evidence of social relationships within the group and to

explore any discernible patterns or changes over time in such arrangements.

Analysis of the process of the group's development was based on all the above devices for monitoring and is reported in Chapter III.

Evaluation Instruments

Participant Data Questionnaire

A questionnaire was administered to all participants at the first session, to provide a data base with regard to their backgrounds and experiences as relevant to the program. Additional information gathered included extent of involvement with cancer patients, interest in the program and social involvements with professional colleagues, especially to the other members of the group. The final question on the participant questionnaire was an open-ended question which sought to identify the most problematic issue for each participant in relation to work with cancer patients. (See Appendix 2.) This information provided a base for exploration of changes which might result from the program's impact. After preliminary analysis of responses to this question, each participant was interviewed to explore unclear responses and gather additional data. All individual interviews took place during the first few weeks of the program.

Pretest and Posttest of Attitudes, Feelings and Behaviors

Also administered at the first session and repeated after the program was completed was a questionnaire to gather data on the participants' attitudes, feelings and behaviors in relation to work with cancer. (See Appendix 4.) This pre and posttest was intended to demonstrate any measurable changes resulting from the program's effects.

Follow-up Instruments

The open-ended question on the most problematic issue was administered again at the time of the follow-up sessions in March, 1982. The initial responses in the pretest were returned to participants who were asked to report any changes in their views of the most problematic issue. (See Appendix 5 for sample responses.)

Two other follow-up measures were administered: an evaluation of the program and a ranking of the most significant themes and issues developed during the program. (See Appendices 6 and 7 for sample instruments.)

At the first session of the program, the participant data base and the pretest questionnaires were completed. The two absent participants returned completed questionnaires at the second meeting, providing a 100% response. Posttests were mailed to respondents with a cover letter and completed responses were collected in person at the follow-up meetings in March, 1982. Once

again, there was 100% response.

Development of Instruments

As this study was breaking new ground in exploring the impact of a support program on social workers' ability to cope with their job stresses in relation to cancer, it proved difficult to locate appropriate standardized research tools. An exhaustive search of related literature revealed no instruments which would capture the necessary data for this study. As a consequence, considerable time was spent constructing and refining the instruments referred to above. (For an evaluation of the test instruments, see Appendix 9.)

The questionnaire constructed for the needs assessment phase of the study also formed the base of the participant data questionnaire used in the program phase. (See Appendices 1 and 2.) Difficulties discovered in the survey instrument, even after pretesting, were corrected in the participant data base which was itself pretested by several experts in the field. Expert consultation helped to clarify ambiguities so that any questions open to different interpretations were eliminated and alternative wording was substituted.

For the open-ended question exploring the participants' views of their most problematic issues, careful consideration was given to the focus and wording of the question. Emphasis was placed on depth and specificity

of the desired responses. When the written responses at the pretest stage failed to give detailed data, it was possible to expand on the investigator's understanding of the worker's perspective during the individual interview. Care was also taken when the posttest was administered to encourage the maximum in responsiveness in this informative area. The participants were provided with a typed copy of their pretest answer and a brief synopsis of the supplementary data obtained at the interview. (See Appendix 5 for sample synopsis.) The question was structured to be as open as possible, allowing any negative as well as positive effects of the program to be expressed freely.

A similar procedure was followed for the construction of the pretest and posttest on attitudes, feelings and behavior in relation to job stresses. A Likert type scale of five points was developed for the dimensions of feelings and behavior. Responses were scaled in categories of frequency. Attitudes were measured on a similarly constructed scale of four points, categorizing levels of agreement. Many of the items were similar to those developed by Streepy in a recent study of burnout.³⁵ Of the thirteen items generally associated with burnout which Streepy used in her scale, some were particularly applicable to an instrument for measuring attitudes, feelings and behavior in relation to the stress of work with cancer patients. For example, items

from Streepy's scale which were readily applicable included: "I feel capable of helping clients with their problems," "I feel relaxed and at ease with clients," "I am able to concentrate on and listen to what the client says," and "I have trouble viewing clients as individuals with unique problems."³⁶ Each of these items was used with the addition only of specification to cancer patients. (See Appendix 4.)

Appropriateness of the content was assessed on the basis of the investigator's considerable experience in the field, and was confirmed by pretesting. Review of the instrument by two experts in the field and by social workers at various levels of experience confirmed that the scale provided enough categories for distinctive responses.³⁷ A few items were deleted or changed because pretesting revealed that the intent was unclear. Each attitude, feeling or behavior was included in more than one item in order to provide more meaningful and reliable data. Each area to be explored was approached in more than one way, as items were presented in converse as well as direct forms. To allow for the expression of attitudes and feelings in various ways, multiple items were used. For example, for the feeling of helplessness two items were used: "The complexity of cancer patients' problems make me feel helpless to intervene" and "I feel that someone else might do this kind of work better."

In order to clarify questions about troublesome issues for workers and to establish dominant themes, an instrument was designed to supplement the posttest question on problematic issues. Themes of all pretest responses and interview data were analyzed and listed in an arbitrary order. (See Appendix 7.) Participants were then asked to rank them in order of importance as personal concerns. Because this instrument was developed during the implementation phase of the project, in an attempt to increase the comprehensiveness of the data gathered, and was based on the data provided by the participants in the pretest, there was no time available to pretest the instrument with experts or with social workers comparable to those in the sample group.

The only instrument which was not essentially newly constructed for the study was the program evaluation questionnaire. This was adapted from the instrument developed by Chernesky for evaluation of a training program of similar duration, size of group and program goals. (Chernesky's methods of training included the use of a group of peers to reinforce learning about a peer review system.)³⁸ The format of the instrument was duplicated and many questions were applicable with only minimal changes of wording. Other questions were substantially modified to fit the relevant content for the present study.³⁹

Evaluation of the program, based on data collected with these instruments, is reported in Chapter IV.

CHAPTER II FOOTNOTES

¹Novia Carter and Brian Wharf, Evaluating Social Development Programs (Canada: Canadian Council on Social Development, 1973), p. 55.

²Ibid., p. 81.

³Henry W. Riecken, "Memorandum on Program Evaluation," in Evaluating Action Programs, ed. Carol H. Weiss (Boston: Allyn and Bacon, 1976), p. 93.

⁴Ayala Pines and Ditsa Kafry, "Occupational Tedium in the Social Services," Social Work 23:6 (November 1978), pp. 499-507. See also Herbert J. Freudenberger, "Burn-Out: Occupational Hazard of the Child Care Worker," Child Care Quarterly 6:2 (Summer 1977), pp. 90-99.

⁵Michael R. Daley, "Burnout: Smoldering Problem in Protective Services," Social Work 24:5 (September 1979) pp. 375-379.

⁶For a discussion of the advantages and limitations of purposive sampling, see Irwin Epstein and Tony Tripodi, Research Techniques for Program Monitoring and Evaluation (New York: Columbia University Press, 1978), p. 85.

⁷A similar conclusion is reached by other researchers. See, for example, Rino Patti, Elenore Diedreck, Dennis Olson and Jill Crowell, "From Direct Service to Administration: A Study of Social Workers' Transitions From Clinical to Management Roles," Part 1, Administration in Social Work 3:2 (Summer 1979), pp. 131-151.

⁸Tony Tripodi, Phillip Fellin and Henry J. Meyer, The Assessment of Social Research (Itasca, Ill.: F. E. Peacock Publishers Inc., 1969).

⁹The Oncology Network, a support network of oncology social workers, originally established in Brooklyn. See also Chapter I, footnote 14.

¹⁰Phyllis Caroff and Florence Vigilante, "Age Specific Issues in Educating Professionals to Work with Terminally Ill Patients and Their Families," Journal of Gerontological Social Work 1:4 (Summer 1979), p. 335.

¹¹Ibid.

¹²Ibid.

¹³Ibid.

¹⁴Malcolm S. Knowles, "Innovations in Teaching Styles and Approaches Based Upon Adult Learning," Journal of Education for Social Work 8 (Spring 1972), pp. 32-39.

¹⁵See Social Work Staff Development for Health Care (Chicago: American Hospital Association, 1976) p. 11. It is recommended that each department have an organized plan with funds and time allocated, "consistent with staff needs and available resources." The administrative commitment is balanced by the expectation that a staff member be expected to make a reasonable investment "of his time and money and to assess his needs and the best means of meeting them."

¹⁶"East End Hospital" is a pseudonym employed to increase confidentiality for program participants.

¹⁷A report of the findings of the survey was sent to each worker who participated at East End Hospital.

¹⁸At the time of completing this final report, early in 1983, the investigator learned that one group member had taken a newly created position at the hospital as an oncology worker.

¹⁹During 1980, a staff workshop was conducted by representatives of the social work department of Memorial Hospital. The focus was educational, giving information about cancer and suggesting the need for workers to examine their own feelings in relation to the work. One workshop leader, in a personal communication to the investigator, noted that members of the hospital staff seemed eager for more exposure to the topic.

²⁰The investigator, as a former Assistant Director in social work departments of other New York hospitals, had related to the Associate Director as a peer and colleague for many years.

²¹At the time of completing this report, several former social work assistant positions had been converted to MSW positions, changing this ratio.

²²At East End Hospital, in contrast to many other major medical centers, no employees are unionized.

²³In recent appointments of administrators of large social work departments in hospitals in the New York area, younger women and, more notably, many men (particularly those holding doctoral degrees) have been selected. This trend breaks with a longstanding tradition of female leadership in a primarily female profession. East End is one of the few major hospitals with a female Director of social work appointed twenty years earlier.

²⁴Hyman J. Weiner, "Demand for Rehabilitation in a Labor Union Population" (D.S.W. dissertation, Columbia University, 1964), p. 126; and Gerald F. Topitzer, "The Effect of Psychosocial Factors on the Rehabilitation of the Cancer Patient" (D.S.W. dissertation, Columbia University, 1975), p. 18.

²⁵Howard S. Becker et al., Boys in White (Chicago: University of Chicago Press, 1961), pp. 15-16.

²⁶S. M. Miller, "The Participant Observer and Over-Rapport," in Issues in Participant Observation: A Text and Reader, eds. George McCall and J. L. Simmons (Reading, Mass.: Addison-Wesley, 1969), p. 88.

²⁷Ibid.

²⁸McCall and Simmons, op. cit., p. 104.

²⁹William Foote Whyte, "Observational Field-Work Methods," in Research Methods in Social Relations, eds. Marie Jahoda, Morton Deutsch and Stuart W. Cook (New York: Dryden Press, 1951), p. 500.

³⁰Pierre M. Turquet, "Leadership: The Individual and the Group," in Analysis of Groups, eds. Graham S. Gibbard, John J. Hartman and Richard D. Mann (San Francisco: Jossey Bass, 1974), p. 350.

³¹Ibid.

³²Once the sample group was established, members were asked about relationships within the departmental structure and their possible implications for the development of the support group. See Appendix 2 for sample questionnaire.

³³Joan Streepy, "Direct Service Providers and Burnout," Social Casework 62:6 (June 1981), p. 360.

³⁴Turquet, op. cit., p. 353.

³⁵Streepy, op. cit., pp. 352-361.

³⁶Ibid.

³⁷The reviewers were acknowledged experts in the cancer field and social workers at hospitals comparable to the implementation site.

³⁸Roslyn Chernesky, "A Training Program to Prepare Social Workers for Professional Review" (D.S.W. dissertation, City University of New York, 1976).

³⁹Question 2, for example, which is concerned with coping, was adapted to be relevant to the topic although using the format of Chernesky's questionnaire.

CHAPTER III

FINDINGS: THE GROUP PROCESS

Introduction

This chapter reports on the implementation of the project. It presents the social context of the program, the curriculum plan, attendance records and an analysis of the group program. A framework was developed for analysis of the content themes of the program as well as of the process of its development as a source of support and mutual aid. Thus, the themes, stages of development and structural aspects of the group, such as its communication patterns and leadership, are analyzed. The chapter concludes with an analysis of the group's development of the process of mutual aid.

The Social Context for the Group

Any group both influences and is influenced by the environment within which it takes place. Gitterman has noted the impact of both sanction and environment on the formation and progress of a group.¹ Cartwright and Zander state that the social environment of a group "exerts an influence on the structure of a group."²

The model support group was formed within the work environment of its members and as part of a large organization. The nature of the environment had important implications for the structure and development of the group.

As indicated in the descriptions of the setting and the sample group in Chapter II, this is a large social work department in a very large and complex medical center. A goal of the department is to have social workers located in individual offices in the area of their assignment. For example, a worker assigned to the pediatric clinic would have an office in that clinic. At the time of the study, many workers were already located in their work areas but others were housed in a group of offices in an old building, far from patient care areas and with difficult access. This location made it hard for patients and families to find the workers. It was also a source of dissatisfaction to workers because of its "unattractiveness" and remoteness from the "mainstream" of the hospital.

The decentralized location of workers' offices has both advantages and disadvantages.³ Patients and families have ready access to the worker (which can be seen as both advantageous and disadvantageous). Professional colleagues have greater access to the worker and themselves become more accessible, with the result that the worker becomes better integrated into the health care

team and may derive satisfaction and support from that position. Yet, at the same time, the worker's access to social work colleagues and opportunities for professional support and validation are diminished by a lack of daily interaction with other social workers.

At East End, the loss of communication which results from the decentralized office pattern is heightened by the lack of a central social work office. In other hospitals of comparable size, social work offices are dispersed but there is a central office with a reception area, departmental resources, offices for secretaries and administrators and sometimes a library and conference room. Through this office, workers have regular, if brief, contact with their administrators and frequent opportunities to interact with peers. At East End, the only central office is a secretarial office too small to permit any of the informal discussions among peers which are common in other departments.

Difficulties in communication were acknowledged by administrators of the department who noted that the workers who seemed to find opportunities to talk in small, informal groups are those located near each other. The younger and newer members of staff also seemed to find occasions to talk, such as during lunch dates.

The Culture of the Department

The lack of communication which results from the physical isolation of offices is supported by the department's norms of independent work. Supervision is provided to teach beginning workers the job, to assist and monitor case management and to offer emotional support related to job stress, but the supportive aspect may not always be emphasized.⁴ An administrator who helped to plan this program gave implicit recognition to deficits in the departmental support system when she described a primary motivation of potential program participants as "to obtain support."

There is an air of formality in staff relationships which may be related to a somewhat formal style of leadership on the part of the director and senior staff. The existence of problems in communicating across the staff hierarchy was acknowledged, and the investigator was told that a prior program on group work had been valued for increasing the staff's comfort in going to administrators about their problems.

The staff's limited opportunities to meet in groups, together with the formal and hierarchical administrative structure, produced a lack of comfort and trust in revealing practice and problems to both peers and supervisors.⁵

Departmental standards for practitioners are high but the practice methods employed are not especially

innovative. As an example, there is little group work performed in a setting rich with opportunities. A more traditional casework approach, relying on referrals to the workers, predominates. As a consequence of its stability and traditional approach to practice, the department is not highly innovative. Other observers have noted eagerness for new ideas from outside the department.⁶

No groups within the department had offered an experience of the kind proposed for the support group. Among those who chose to participate, relationships varied greatly, as reviewed in the data on social relationships presented in Chapter II.⁷ Since the group was established in their workplace, the group members needed to preserve or develop peer and supervisory relationships during the program which would remain appropriate for their continuing daily lives on the job.

Thus, the group began with major environmental influences: workers had no previous experience of the kind of group or peer support proposed, they lacked comfort and trust with each other as well as the leader and they had to overcome differences between workers and supervisors. While these factors predisposed the group to difficulties in developing a sense of cohesion and ability to help each other, their influence was balanced by a real hunger for such an experience of support and sharing. This was apparent as members described what they would like to have, and rapidly began to take the

risks that they doubted were possible.

Curriculum for the Project

Content for the curriculum of the support program was derived from findings of the needs assessment and from the investigator's expertise in the cancer field. The curriculum (see Appendix 8) was intended to provide guidelines and identify topics of anticipated interest, and the program was intended to relate the specific content of the sessions to the workers' objectives. There were several reasons for this. As adult learners, the group members were expected to learn new skills or acquire new knowledge through identification of their own interests and needs.⁸ The core model of peer group mutual aid also assumed adult, professional members who would actively participate in defining their own objectives within the program. It was anticipated that some new learning would be a component of the support system to be developed, but the extent of knowledge and information which would constitute the cognitive component of such support was not known. It was hoped that the involvement of the members themselves in selection of the program content would lead to the development of a model which could be used in any hospital social work department, with specific content related to that department's own perceived needs. As a consequence, the written curriculum was not distributed but the agenda presented to the

members was open to their suggestions. Broad guidelines were laid out: namely, that the group should relate to their work with cancer patients and focus on their management of stress experienced from the work; that the investigator would provide information or resource material as needed; and that the members were expected to develop specific topics for the agenda.

Implementation and Attendance

The group met weekly for one and a half hours for nine weeks. The initial session was extended by 15 minutes because the administration of the study's data collection instruments was estimated to take 15 to 30 minutes, thereby shortening the important introductory session. At the eighth and last planned meeting, members requested an additional meeting. The process of assessing gains and bringing the program to a close was seen as unfinished. Because of other commitments, the next date possible was one month later. The ninth session was held in a different room but at the same time as all previous meetings.

Attendance records were maintained throughout the program. There were never less than seven members present and the mean number attending all sessions was eight. At times, workers were unable to attend group meetings because of work demands. For the most part, however, absences were explained by illness, vacations or

professional commitments such as attendance at a national conference.

Table 8 gives the frequency distribution for attendance.

TABLE 8
FREQUENCY OF ATTENDANCE

Number of Sessions Attended	Frequency	Percentage
1 - 3	0	-
4	1	10
5	0	-
6	1	10
7	2	20
8	5	50
9	1	10
Mean = 7.3 Median = 7.8 Range = 4 - 9 sessions		

Only one member was present at all nine meetings. Eight of the ten participants attended seven or more of the nine group sessions. One worker who attended only four sessions was an active participant when present. On one occasion she sent a message that she was prevented from attending by emergency needs of clients. (While the occurrence of emergency situations is not uncommon, workers deal with the balance of client and group commitments in a variety of ways.) The worker who was frequently absent from the group was very interested in the topic of cancer, expressed considerable difficulty in

managing her feelings about that aspect of her work and spoke very openly when present. Soon after the program's termination the worker changed to an assignment which gave her less exposure to cancer patients.

Termination of the program was difficult for the group. They spent part of the final session developing plans for a continuation program for all members who wished to attend. The group would not be open to other members of the staff because, despite some uncertainty about their goals, they saw a need to maintain the pattern of support and communication which they had begun. Although uncertain about the probable effects of continuing without a leader, they planned to meet every other week at lunch-time, on a regular day with a room reserved. Three members were present at one, and six at the other, of two meetings that the investigator was able to attend.

All ten members completed the questionnaires providing data for the study and all were available for individual interviews.

Framework for Analysis of the Group Process

Group methods are increasingly valued in social work practice as the findings of research in the social sciences suggest that groups may be effective for varied purposes.⁹ Groups may be useful for helping individuals learn or adapt and for "collective action between and among people for problem-solving, system change and

societal change."¹⁰

In planning group programs, practitioners must take into account a range of factors including:

- Group purpose and task
- Composition and recruitment
- Size, time-span and location
- Organizational sanction and support
- Leadership¹¹

Similarly, these factors must be considered when a group is studied to assess its progress and success. Within social work practice literature, Hartford's framework for examining group processes includes the areas necessary for group formation, with the additional categories of phases of development, interaction processes, decision-making and culture.¹² Northen, identifying the major concepts of groups as units of social work practice, notes social interaction, purpose, affective ties, status and role, subgroups, values and norms, conflict, group cohesiveness and stages of development.¹³

Comparable concepts are identified in social science research which studies the processes of groups. As Hare states, the variables that affect the interaction process of groups include the personalities and social characteristics of members, the size of group, its task, the network of communication and its leadership.¹⁴

Because of the complexity which results from the integration of these multiple variables, systematic analysis of a group and evaluation of its achievements present a challenge to investigators. In this study,

records, logs and tape-recordings provided a wealth of data about the study group. In order to analyze and assess the group's progress and the extent to which it achieved its goals of peer support and mutual aid, the investigator developed a framework for analysis which drew upon several theorists.

Hare has pointed out that the relationship of elements of social interaction may be examined from the point of view of process, structure or change.¹⁵ From the process viewpoint, examination focuses on the sequence of group events over time. The structural approach focuses on the relations between elements of social interaction at a given time. Thus, roles, statuses and communication patterns may be studied in order to understand the nature of a group. A third viewpoint considers group interaction by looking at change that occurs in the structure over time.

Methods of analysis which focus on the stages of a group's development over time are useful for analyzing the group's progress from formation to termination and for examining points of change.¹⁶ Generally, however, they do not provide methods for examining elements of social structure such as group composition, sanction and environment, status and role and patterns of communication. Other models of analysis focus on the internal processes of the group¹⁷ or on detailed analysis of portions of the interaction, by examining critical inci-

dents.¹⁸

One model of analysis which took a developmental, or process, approach attempted to incorporate group structure and task behavior -- the nature of the group's work -- at each of its stages.¹⁹ Tuckman examined structure and task activity, but his analysis of structure was limited to assessment of the communication patterns directly related to his four-stage schema. He did not examine the interaction of the group process and structure in the broader sense, including such elements as status, roles and composition. Task activity was analyzed only in relation to its relevance to the four stages of the schema.²⁰ While Tuckman's framework leaves gaps in terms of structural components and thematic content, it provides an important base for the development of a framework for group analysis.

Thus, the work of social work practice theorists provided major concepts for establishing a framework for analysis of the group. Purpose and task, group size and composition, time, organizational sanction and leadership were all considered in the development of the support program and remained critical elements for its analysis. In addition, the work of social scientists such as Bales, Hare, Tuckman and Garland, Jones and Kolodny provided models of analysis which emphasized the interactional processes, stages of development, social structure and thematic content of groups.

For this study, the investigator deemed it important to examine not only the sequence of events in the group but also the nature of the social structure which facilitated or impeded that sequence, and which was itself affected by the developing process. It was considered important to develop a holistic perspective of the development of the group and to look at the interaction of the group's process with its content themes, rather than to focus on detailed analysis of selected portions. In order to analyze the nature of the interaction of thematic content, structural elements and group process, the following framework was developed, in an attempt to synthesize and incorporate the essential elements derived from the theory and research reviewed.

1. An important element of the framework was the incorporation of content as well as structure and process. The study's intent was to develop a peer support mechanism in relation to the specific professional functions of social workers with cancer patients. The content of group discussion was reviewed and analyzed in order to identify themes of significance for support groups in this area of practice, including the stress experienced by workers, ways of coping and the role of the group program in meeting the need for support.
2. The developmental process of the group was reviewed phase by phase and included summaries and highlights

of activities at each phase and analysis of changes of focus.

3. Group purpose, task and composition, including a detailed analysis of members' self-reported data, were described in Chapter II and are referred to here only as they are related to the other variables. Data regarding personalities of members were not specifically collected as this did not seem appropriate to the group's professional or research purpose.²¹ Some personality characteristics emerge in the review and analysis of the group's progress, particularly in relation to the extent and nature of participation.
4. Communication patterns and leadership as they interact with the developmental phases of the group were analyzed. (Assessment of the interaction of environment with other variables draws on the analysis presented of the social context of the group.)
5. Finally, since a primary purpose of the program was to develop a system of mutual aid, the nature of that process was analyzed separately.

Themes of the Group

Many themes emerged in the course of the program, some of them for brief discussion and others for elaboration and development over several sessions.

Many were topics related to sources of stress and coping patterns. In both these areas, the work of Koocher

offered a useful framework for analysis.²² The major stresses identified by Koocher were troublesome symptoms, such as a sense of helplessness; difficulty seeing value in the work; guilt associated with a sense of omnipotence; exclusionary protectionism and "difficult" patients, such as those who greatly deny their feelings. Coping strategies noted by the professionals in the study were as follows: making use of hobbies; working with a variety of patients; mutual support from colleagues; alternate work assignments; use of humor; taking time off; sharing the sense of helplessness and limited emotional investment.²³ Not all elements identified in Koocher's study were applicable to the themes of the present group but, particularly in regard to coping strategies, there was considerable replication of Koocher's findings as social workers in this study discussed their strategies for coping with job stress.²⁴

The specific categories presented here are based on major elements of the study and include themes related to the formation, process and outcome of the group program.

1. Themes Related to
Cancer Patients

As members of the group sought to understand the elements of their work which caused stress, they identified aspects specifically related to their patients.

Several members were concerned about the lack of resources to meet the frequently extensive needs of their patients. Gaps in available services were sources of frustration to the workers. Some perceived the hospital system's depersonalization of patients as a primary source of frustration for worker as well as patient. This area of concern was closely related to the distress of the workers when they perceived the treatment plan for a patient as meeting the needs of medical research rather than the patient's comfort.²⁵ Stonberg has described the special responsibilities of social workers who are "often involved in helping patients confront feelings about the participation in treatment regimens that may have little to offer in terms of cure but that might contribute to research findings."²⁶

This topic was the focus of an animated discussion in which some workers spoke angrily about apparent excesses of treatment with terminally ill patients. References were made to the "torture" of drawing blood and to patients being treated as numbers. The active level of care pursued in an acute care hospital, and particularly in a teaching center, contrasts sharply with the palliative care of a hospice or institution for the terminally ill.²⁷

There was consensus about the failure of the health care system to meet the needs of patients. Members of the group expressed frustration, anger and de-

pression about the experiences of their patients.

Characteristics of patients were discussed at different times in the program. Workers stated that they found it difficult to work with clients whose families were so protective that the nature of the illness was concealed from the patient. In those circumstances the worker's ability to help was hampered, frustrating the worker. Similarly, patients who consistently denied their illness and their consequent needs were also seen as difficult to work with and contributors to the stress of the job. Workers found it hard to leave a patient with less than the maximum potential service. At the same time, some workers recognized that their own spirits would be buoyed by the strength of a patient. As one member said, acknowledging the need of the worker as well as the client for courage and sustainment, "We do love the heroic patients, don't we?"

The development of these themes indicated that workers found the nature of their clients' needs and use of their services stressful and demanding.

2. Themes Related to Cancer as a Disease

Repeated discussion, in various forms, of the impact of cancer on the workers, suggested that they were subject to the varied responses of fear, depression and hopelessness also noted in the wider society. At times, members interjected comments on how depressing the

topic was.

Fear and horror of the disease were expressed by all members. One member spoke of a struggle to understand the horror and thoughts that ranged across decay, loss of control, pain, stigma and contagion as aspects of the disease. Another said, "There's no disease I want less. It's absurd, but how I feel. It's gruesome, it affects all your organs; it's full of unknowns. It's scary even when you work with it and build up an intellectualized way of dealing with it."

Disfigurement and pain were distressing to most members of the group. They spoke of difficulties in coping with feelings about the appearance of very sick and disfigured clients. Cancer was equated with death by one worker. The statement represented the repeated expressions of all group members that even though cancer is not the primary cause of deaths, it is a primary source of fear. A sense of pessimism and hopelessness about the illness was expressed in various ways. During the course of the program, a young cancer patient was featured in the New York Times and was reported to be doing well. He was a patient at East End Hospital and the group talked about the article. Members expected him to die, despite optimistic predictions. One worker said, as the group reviewed the pessimistic attitudes of the members, "And meantime he's not doing so well," thereby confirming the group's predictions.

On another occasion a member expressed lack of faith in the effectiveness of either radiation or chemotherapy and said, "Once you have it, you die." There was a brief silence and the worker continued, "What am I doing being a cancer worker?" Another worker talked about the despair experienced by patients facing death and the burden placed on the worker. The feeling of wanting to just walk away from such despair and pain was expressed. It was also pointed out that the social worker's perception of the disease was biased. A member said, "Most of my patients die in two years. Those we don't see are those who make it."²⁸

3. Themes Related to the Worker's Response to Stress

Members spoke with sadness of clients who died and expressed feelings of loss and grief. There was variation in the degree to which members became close or distanced themselves from clients and, consequently, variation in the extent of the impact of loss. One member stated, "I may like someone very much, but I don't allow myself to feel that much of a loss." Others connected their reactions to personal losses and another member suggested that what the workers experienced was less a personal loss in relation to a client than feelings springing from the worker's identification with the client -- or, as the worker expressed it, "the counter-transference -- the substitution in my head."

Identification with clients and its consequences in sorrow, grief and depression were major themes of the group. As the group developed trust, members openly expressed differences in their experiences of identification and their ways of coping with it.

4. Job Related Stresses

Stress on the job was seen to come from several sources beyond the client and worker stresses. As discussed in relation to the group's environment, the department's culture left workers feeling isolated from each other and lacking systems for communication and support. Members spoke about not knowing each other and lacking opportunities to discuss their feelings about the job. They felt that supports within the department were sparse and that workers did not all receive adequate emotional support from supervision.²⁹

One session of the program focused on the lack of support for workers in the department, and parallel lack of support for the department and its function within the hospital.³⁰

As Toren has recognized, bureaucratic organizations may interfere with the service orientation of professionals -- "with the professional commitment to place the client's interest above all others."³¹ Members of the group discussed the dilemma of serving two masters, the client and the hospital.³² One asked, "Who do you

work for? The patient? The hospital?" Another spoke of having "separate contracts" with patients and doctors as a result of divergent value systems.³³ At another session, members picked up this theme again and spoke of feelings of being manipulated as well as a discomforting sense of manipulating others. They felt manipulative in their efforts to meet patients' needs and to collaborate with institutional needs, such as discharge to a nursing home. A member said, "I'd rather get yelled at for doing something for the patient...you are here for the patient." Another responded, "Are you, are you?" The former speaker replied, "I like to think so, but sometimes we're not...." The frustration and anger expressed by group members about the job, its limited rewards and supports, the department and the hospital were ultimately linked to another powerful theme. Connections were perceived between the frustrations felt in relation to the lack of rewards and the deeper frustration of being unable to save the patients. The worker from pediatrics said, "There's a sense of impotence that we can get into. It's a trap to stay out of."

Social workers felt a responsibility to help their colleagues with the stresses of cancer work and found themselves acting as supports to nurses and doctors.³⁴ Members accepted this as an appropriate role but pointed out that it was more difficult for them to obtain support themselves. One said, "Who takes care of

me? I talk about their feelings with the patient, the family, the doctors, the nurses and so on. No one helps me."

When asked about the value of supervision, the worker stated, "What goes out is greater than what goes back." The notion of the worker as a repository of sadness and stress was expressed in the description of the worker as a "container." On another occasion a worker asked, "Where do I go? We give a depressed doctor a chance to talk, but the social worker is left without help. Consultation and supervision are not used that way."

Another aspect of job stress was identified as the variability of caseloads. All members carried mixed assignments and all had the experience of variation in the number of cancer patients referred. There was a sense that the volume of such work was important and that beyond a certain point, each had difficulty coping and providing the service normally given. Comments were made such as, "when you are overworked you cannot deal with it," referring to a particularly stressful situation. On another occasion a member said:

When I have five or six cancer patients at one time, I cannot deal with it. I have to space it out. I feel guilty if the patient is not getting good service. I do a better job if it's my only cancer case. After a certain number, I personally cannot take it. I cut the patient off. Sometimes I don't do even a decent job....

5. Satisfactions

Despite the many stresses of the job, all members expressed commitment and set high standards for their work. One member had doubts about continuing with an assignment that involved many cancer referrals, and after the program's termination, changed assignments. For the rest, however, the job was acceptable and well enough rewarded to be worthwhile. Many of the discontents were balanced by recognition that if not ideal, things could be worse. When workers were speaking about the lack of departmental supports, the same worker who spoke angrily of the staff's lack of rewards noted that another agency, mentioned in glowing terms by another member, left much to be desired in areas that were acceptable in this department, such as the benign nature of the administration. Among the more positive satisfactions was the support and collaborative work with many of the nurses and some doctors. The effectiveness of teamwork was exciting for those who experienced it. They simply wished that they had more such experiences.

Other satisfactions were derived from the direct work with clients. The following excerpt illustrates the satisfaction felt at doing good work.

- A. "When I have a good interview and the patient is talking to me about his feelings, even a patient who is dying, then I think, wow! This is why I went to school."
- B. "It is rewarding."

- A. "It's a good feeling, but draining. What makes it better than others is the patient's ability to relate to what I can offer. It's exhausting, but exhilarating."

The overall impact of the job also was seen to have value for the workers. They became more aware of "the preciousness of days" and more appreciative of small wonders of nature. A member said that she had learned from patients to appreciate so much more. Another expressed gratitude for the experience of the work. She said that she does things now and does not postpone as people do, saying "I'll do it someday."

6. Coping Patterns

The growth of trust and mutual aid in the group led workers to share experiences and offer suggestions for coping with the stresses of the work.

As indicated in reviewing other themes, there was discussion of a pattern of withdrawal from clients. The prevailing norms of the group were such that this was a pattern presented as unacceptable behavior, causing guilt for the worker. There was, however, a balancing value system. Some workers were able to accept a degree of variation in their practice at times of pressure and, as noted earlier, some generally maintained greater emotional distance from clients than others. A coping system which relied on detachment and ability to separate from the job at the day's end was to some extent used by most workers but seemed to be more regularly used and

more accepted by two very senior members of the group.

One spoke as follows:

It changes as you get used to the job. You leave that part of your life behind. You do the best you can and sometimes leave late, but I don't want to think about it at home. I'm exhausted by the end of the day. I try to divorce it. After 19 years...you cannot think about the job for 24 hours a day, or you are dead.

Most workers tried to escape from the stress of work by active involvement with families, friends or unrelated activities at the end of the day. To some extent, members seemed ambivalent about the desire to speak with family and friends about emotional stresses of the job. Several people talked of leaving work behind, yet they participated in a discussion of the fact that outsiders to the work do not really want to hear about it, suggesting that they may, at times, have such discussions. When one member stated, "Your family doesn't want to hear about it," there was laughter and acknowledgment from the entire group.

Religious beliefs were also used by several workers to help put the distress of their work in perspective. For the majority of the members religion was not a primary support but they were acutely aware of the value and comfort of religion for many of their clients. One worker said that she had run to the chapel at lunchtime when feeling very stressed and vulnerable.

7. Balance With Other Work

As indicated in exploration of the theme of job related stress, the sheer volume of work with cancer patients was considered an important factor. Workers felt that they had a saturation point, beyond which they could not offer their best services.

Workers did not always feel that they were coping well with such a situation, and guilt was expressed about the poor quality service received by a patient who follows a series of other cancer patients and finds the worker already depleted. One coping mechanism available to help workers with the volume of work of an intense and stressful level came from the variety of their assignments. Workers could retreat from the stress of cancer patients to work with other patients and to work less directly related to patient needs. One member whose caseload included obstetrics as well as gynecology talked about the value of the mixed assignment saying, "There is a variety; they are not all dying and I get a lift from that."

8. Peer Support

Members regretted that there was not more peer support within the social work department, as discussed in reviewing the environment and culture of the department. To the extent that such sharing did take place, it was welcomed and seen as a real aid to coping. Although

some members reported that much of their work with colleagues from nursing and medicine was focused on giving rather than receiving support, others identified the interprofessional team as a source of support. One member stated that she had given up the effort to find trust and communication within the department. She said, "I need all my energy for my caseload and I have developed my own way of coping. I go back to the staff on my floors. They also know the patients, and we can talk about how we feel."

Sources of peer support outside the hospital were also valued. One member found the Oncology Network to be a strong support.³⁵ During the course of the program, a member was away at the annual conference of Pediatric Oncology Social Workers for one session.³⁶ In describing his experience there, he said,

I came back with energy. Being able to discuss your work with peers, people who are doing the same things, can confirm things, affirm your fears as like theirs, and make you feel less alone. I find something like that helpful and even inspiring.

9. Supervision

As previously indicated, the topic of supervision was important from several points of view. The impact of the presence in the group of both supervisors and their supervisees has already been discussed. Supervision was also discussed as an aid to coping with job stress. Most workers used supervision primarily for

management of their cases and to a lesser extent for ventilating strong emotions related to the work.³⁷ Although supervision had been acknowledged as a source of professional stimulation in the preliminary data questionnaire, it was evident from group discussion that it was not seen as a primary means of support in this setting. Even members who felt that their supervisors listened and cared about the stress they experienced, did not find supervision to be an adequate system of support. The central difference perceived between supervisory support and the support of peers was in the mutuality of the supportive process. Supervisors gave support as an administrative responsibility. If they were also direct service workers themselves, their support was thought to be more focused on the issues of concern to staff. Nevertheless, their role as supervisor prevented the support being mutual. As one supervisor in the group said, "As a supervisor, I'm supposed to dump up, not down!" The system of supervision was established with supervisors giving answers and it was not intended that supervisors go to their supervisees for help.

10. Training

Despite the investigator's expectation that a peer support group would identify training needs as part of the support program, interest in training played a minor role in the group's progress. There were differ-

ences within the group, but it was a minority who requested training content as part of the program. The process of mutual aid which developed included the exchange of information, and this was welcomed as it occurred with the process but not desired as a separate focus. One member said that some training had taken place within the sharing experience. There was consensus that "support cannot work without information" and that if the group were to continue, training might have a more significant emphasis. Interest was expressed in topics such as changes in treatment and their implications for patients' life-styles and methods of approaching dysfunctional avoidance or denial by patients and families. The group was contrasted to other activities of the department in which the primary emphasis had been on learning, with the consequence that group development was neglected. Members thought that it had been important to focus on their relationship to each other within the group in order to work through the process and emerge able to relate to each other openly and supportively.

11. Group Tasks

The group's primary concern with the development of open and supportive relationships led to frequent discussion of the task and process of the group throughout the program. Members openly discussed their efforts to come to know one another, to develop trust and to take

the risk of exposure of both practice and feelings about the work. Some themes which emerged have been summarized in relation to their specific focus, such as taping and confidentiality and the relationship of supervisors and line workers.

During the fifth session, in the middle phase of the group's development, when the group was pulling back from the initial phase of intimacy, one senior member asked whether the younger and less experienced workers were those more interested in obtaining help and in working through the process of becoming open enough to establish mutual support.³⁸ This was the same member who had asked during the preceding session if the leader would help to establish an ongoing support group. Thus, her pulling back seemed to have more to do with the stage of development of the group than actual disinterest in support.³⁹ Younger, newer staff responded that they had expressed greater dissatisfaction at the previous meetings because they had offices that isolated them from colleagues. They related the lack of a supportive milieu to their need of emotional support for their cancer work. Another senior worker then spoke about her interest in support, and a younger member suggested that hesitation over the need for support might result from members' concerns about being more open with each other. After she stated that support meant getting close to each other and that it was not easy to do, the discussion became more

active and focused on the value of group support.

12. Value of the Group
and Continuing Need

Recognition of the value of the group was expressed from the third session until the end of the program. Members commented on the sense of unity which they had achieved by openly discussing the stresses that they experienced. In the fourth meeting, one worker noted the benefits of the group's normalization of what had previously seemed to be peculiar concerns and fears. The group was referred to as a source of sustainment. One worker was going to be away for a week and members acknowledged the value of the group when they joked that they would tape the session and mail it to the worker. From time to time, there were comments such as, "I'm learning something from this," or "That was helpful," or there were thanks from one worker to another. During the termination stage, members specifically identified the value of the sharing and mutual aid processes of the group. Aspects of this are highlighted in the report on the mutual aid process.

Members of the group felt that they had gained support and aid from the program but the task of meeting their needs for support was incomplete when the program came to its end. It had been clear for several weeks that the majority of members wanted to continue to meet. There was uncertainty about the effectiveness of a leader-

less group but the members were eager to attempt to continue as peers to provide a forum for mutual aid and support related to their cancer work. The continuing need for the group was expressed by one member who said:

We are people who deal with feelings, and we recognize the importance of letting feelings come out. This is to say, we do it for patients, but we don't do it for ourselves. That is what is wrong with our department. Business provides outlets that we do not. And that is just what this group provides the most -- and that's the value of it.

Stages of Development

The group's development is traced through four stages: the initial phase; intimacy; a middle phase and termination. The stages are based on a synthesis of the work of several authorities.⁴⁰

The Initial Phase

The first meeting of the group set the stage for future developments. The task and purpose of the group were identified by the leader and included the development of specific agendas by the members. Introductions were made and the investigator's research purposes were explained. The members' permission to tape record the meetings was obtained. A contract for the ongoing work of the group was initiated but, because of the absence of three members from the opening session, was reworked at the second meeting.

Much of the second session was devoted to including members who had missed the first meeting. The

contract began to emerge more clearly as workers raised questions about their potential use of the group and as they introduced topics of interest to them, such as over-identification with patients, fears of cancer and its equation with death. Despite initial hesitation, there was open discussion of stresses and ways of coping with cancer patients. The two sessions were characterized both by tentative efforts to become involved in a supportive process and by the hesitation resulting from uncertainty about trust and appropriateness of content.

Members had to overcome the anxiety associated with exposing examples of their practice and personal reactions in a group which included supervisory staff, little known coworkers and an outside leader. This stage of the group's development may be seen as the "pre-affiliation" or "approach-avoidance" stage of beginning groups identified by Garland, Jones and Kolodny.⁴¹

Intimacy

The third and fourth sessions of the group were characterized by a high level of spontaneous member participation and the emergence of many important themes related to stress and the need for support experienced by the members, such as the isolation of offices from other workers, the lack of a support structure in the department and the demands of being a "helper" to colleagues in other professions. Some peer support and mutual aid took

place at each of these sessions. Despite their predictions to the contrary, the workers spoke openly and with investment in the process of getting to know each other and identifying mutual concerns. The climate, during both sessions, was intense and excited, with considerable humor emerging. The workers were pleased with the process taking place and the suggestion was made that they form an ongoing support group which would take place when this program terminated.

Both sessions involved a high degree of intimacy and sharing which were manifested in eager talking and responses, humor and supportive agreement. In one instance, a worker described the lack of support received from family members who, after hearing about difficulties of the job, proposed that the worker "do something else." This was greeted with laughter by the group and then two other members rapidly continued the theme of giving support to others but receiving little support or encouragement.

The move into an intimate phase of the group occurred very rapidly, and as it later became apparent, quite precipitously. This second stage of the process deviates from the pattern observed by many investigators.⁴² It approximates more closely the third phase frequently observed in a group development, and omitted the intervening phase of "power and control."⁴³

The Middle Phase

The fifth and sixth sessions were of a different character from those preceding. The rush to intimacy of the earlier sessions was followed by a drawing back and caution on the part of most workers. This was evident in that both meetings had lengthy periods of silence. Members also referred to the heavy atmosphere. Content of the meetings included evaluation of the group to date and reflection on the development of trust and intimacy. During the fifth session there were references to "the struggle" experienced about whether to become close to each other. As workers recognized the change of climate from earlier sessions, one commented that the closing of the previous intense session "should have been the end of the group." Another identified the uncertainty of not knowing if the group should be a place for sharing and support or should refocus on training. The worker commented on the strained atmosphere of the group, saying, "that is the heaviness -- we're not sure which direction we want to go."

After discussion of the earlier phase and the group's difficulty in focusing on cancer-related topics, the contract of the group was explicitly reestablished with a firm commitment to dealing with workers' feelings about cancer and the development of peer support. In accomplishing the renewed contract, members reviewed their premature rush to intimacy, its effects and impact.

The lack of open discussion in the department was referred to, and a sense of mistrust was identified. One worker expressed doubt that there had even been much openness so far, stating that the members had "only put their toes in the water." Others thought that pulling back had occurred and one noted that "after an open and heated group, repression came. A process had taken place...." During this phase of the group, questions about the leader's role and authority emerged. One worker stated in the sixth session that "there is a lot of authority -- we're not used to it from you -- you gave so much focus today, and a goal." Another worker followed this by stating that they might not only fear intimacy with each other but that the investigator "will publish this...whatever we say here will come out." The same member stated angrily that the leader was not being open and that there was pressure to talk because "if we don't talk, you don't have material." Other members dismissed these concerns but they crystallized the struggle for establishing roles, trust and power essential to the movement of any group. This stage of the group, therefore, most closely approaches the "power and control" phase referred to above. Many reasons for the sequence of these phases may be identified, among them the sense of urgency and eagerness for a support system. Other important elements are the urgency created by the eight session time-limit of the program and effects of the

leader's activity, which will be analyzed below.⁴⁴

After the rapid achievement of intimacy and openness came a phase of drawing back and recontracting. The outcome of that stage was a phase of work in which the group's early ventures into support and mutual aid were developed and consolidated.

The seventh session was a really intense "work" session in which previously cited themes of the stresses and rewards of work with cancer patients were elaborated and developed. The level of participation was very high, with all seven members present contributing. The three absent members were active and forthright speakers when present but their absence did not inhibit discussion. As the theme of the meeting moved from stress and the worker's vulnerability to ways of coping, members shared feelings about the work and told each other about their personal ways of coping with particular stresses. There were many instances of mutual aid as members exchanged ideas and suggestions about ways of defending themselves and developing increased gratification from the work. There were other instances of support, as when a member revealed that her work did not always meet her ideal standards. Other members reassured her that she "couldn't help it," normalized the behavior and made suggestions for coping.

The session was focused directly on the topic of cancer. Several comments indicated that members found

the discussion helpful and supportive. This session could be characterized as the stage of "differentiation" in the five-stage schema of Garland, Jones and Kolodny.⁴⁵ The group had come to grips with its task and resolved issues of power and control, such that members acted responsibly towards each other and the group task. In Tuckman's terms, this is the stage of "functional role-relatedness, the 'performing' of the group task."⁴⁶

Termination

The work phase continued into the eighth and last planned session, continuing themes which had emerged previously, such as conflicts between the needs of patients and families to have additional time to adjust to illness and the hospital's expectation of rapid discharge of patients to home or another facility. New themes emerged at this phase too, as workers spoke of the impact of cancer on their own life-styles. They referred to a special appreciation for small daily activities and pleasures, intensified by the sense of vulnerability which their association with cancer produced.

The level of interaction was high and there were many instances of support and mutual aid. Although this was planned as a session for evaluation of the experience of the program, it was difficult to retain that focus. Important evaluatory statements were made both explicitly, in such statements as "what took place here couldn't

have been resolved individually..." and implicitly, as members pursued the idea of a continuing support group. Yet termination of the group was difficult to accomplish for several reasons. The task remained incomplete, although a mechanism for support and mutual aid seemed to be well-established. For the reasons discussed above, the group had moved through essential stages of development in uncharacteristic patterns and had reached its work phase when only a few sessions remained. During the eighth session two decisions were made. The group would continue after termination of the program, as a lunch-time meeting. Members of the group felt that the termination of the program, the "separation" phase,⁴⁷ was incomplete. The leader accepted responsibility for not having helped the group complete the work of terminating and a ninth and additional session was therefore planned. The additional session was essentially an evaluatory meeting in which the members and the leader shared experiences of the program and evaluated its components. This provided a formal end to the peer support group as initially conceived and separated it from the worker initiated program to be developed.

Participation

The Communication Network

The communication network, or participation patterns of the group, were critical to its development

as a working group. All ten members played an active part in the process. Even the member who attended only four sessions was an important actor who, when present, introduced topics, shared emotional reactions forthrightly and challenged the leader. As there were never fewer than seven members present, there was a variety of ideas, opinions and experiences to draw on at each session. Every member present spoke at least once during each meeting, with one exception. The worker who did not speak during the seventh meeting, a highly active work session, was not feeling well but had chosen not to miss the session and appeared very involved as a listener.

Investment in the group was apparent when workers who missed a meeting spoke to others to ascertain what had happened at the session. It became clear that the group was discussed outside its meetings, at least between members who were friends or close colleagues. In the initial sessions, the leader was very active, suggesting topics, asking questions, responding to members' questions and inviting participation, especially from the less outspoken members. Some workers were eager to talk from the outset, while others were cautious and seemed to want greater clarity about the purpose and potential consequences of the discussions.

As the group progressed and members came to know each other and the leader, there was increased spontaneity in the discussions and direct interchanges among

members, without participation by the leader. This spontaneous pattern of communication was interrupted by a pattern of resistance and reluctance during the middle phase of the program when, as noted above, issues of authority and trust dominated the communication. Typically for that stage of group development, there were many silences and much of the communication involved the leader's stimulation and attempts to have the changed milieu discussed openly. Accordingly, both sessions five and six were punctuated with more and longer periods of silence than other sessions.⁴⁸

Patterns of communication included direct questions and answers, expressions of personal ideas, feelings and experiences, citing of examples to support what others said, expressions of differences of opinion, assertions, exclamations and jokes. Many statements offered support and help to others.

The growth of the process of mutual aid was also aided by the contributions of workers who asked direct questions of one another, as when one member described a particularly difficult collaborative effort with a doctor in planning for a patient's discharge.⁴⁹ The incident was presented with humor and greeted with nods and laughter of recognition by most members. One asked "How did you deal with it?" initiating an exchange of ideas and suggestions.

During the "power and control" stage of the program,⁵⁰ members challenged the leader's authority and the group's ability to develop as a support group. They noted the heavy atmosphere of the meeting in contrast to earlier sessions. One commented that previously she had left the group "feeling good and excited" but that the group now had spent half an hour talking about confidentiality and needed to get back to its proper agenda. This theme was repeated by another member who stated that "mistrust has existed here. Now we need to observe what has happened and move on beyond it." The worker continued, describing the stresses experienced that day in the clinic. The patients to be seen by the worker included a 21 year old leukemic and a 41 year old whose many siblings had all died of cancer. While waiting to see yet another cancer patient, the worker learned from a doctor that another client had died the night before. Describing this as "heavy duty" work, the worker spoke of wanting to go home and of being really depressed. The specific case examples and the worker's openness about their impact drew all members into an intense discussion of similar work problems.

Initiation of Change

Although the leader took responsibility for providing a group focus and for highlighting obstacles to their agreed task, the members had primary responsibility

for choosing topics, defining the focus and establishing the pace and depth of discussions. Those members who seemed comfortable with group discussions from the beginning talked freely about their preferences for topics and ways of proceeding and consistently spoke more than others. This seemed to be related to personal style as well as factors of comfort or discomfort in the presence of supervisors, supervisees or friends. Members of the group spanned a range of one to twenty years of tenure in the department. The relationships of supervisees and supervisors varied, including both cordial but formal relationships and friendships. Those who were more talkative and able to initiate discussion, whether due to personal style, greater comfort with the relationships within the group or a combination of both, certainly furthered the progress of the group as they presented material to which all members responded.

The group's work and ability to overcome obstacles was aided by interventions from almost all members, notably from some who spoke infrequently.

In the initial sessions, leadership in moving the group forward came several times from one of the supervisors. For example, during the second meeting a worker spoke of fears of developing cancer. The leader acknowledged the fear that the worker experienced. The supervisor then asked, "Isn't fear an issue for everyone here?" The question was greeted by a loud "Yes!" from

the group, and the discussion moved rapidly to include other members' fears and the association of cancer with death. Another very experienced worker, although not a supervisor, took responsibility, at different stages of the group's development, for calling the group back to its task and for providing a topic to help the process move forward. For example, during the fourth session, this member began a discussion of the possibility of the department forming an ongoing self-help group. During the fifth meeting, the group felt "deadlocked" after lengthy discussion of "complaints" and "gripes," and had difficulty returning to the topic of cancer. After considerable work had taken place on the issue of trust in relation to the group, it was the same worker who re-focused the group on its initial agenda, asking, "What are we going to talk about? I feel bad about sick, dying patients having to leave the hospital." This break of the "deadlock" and resumption of the original focus was encouraged by other members and the group moved into an involved discussion, not only of the consequences of transfer from the hospital for patients, but also of the workers' feelings and means of coping in such situations.

Reluctance to Risk

During the second meeting, a member whose supervisor was a member of the group, but absent that day, expressed doubt that the workers could be open with each

other about feelings and experiences. Others tentatively disagreed, stating that, since they wanted help in coping, it would be essential to focus on emotional responses to the work. It was a supervisor who then expressed a strong interest in focusing on coping and the workers' feelings, stating that although all members worked as colleagues they had not been open to each other's feelings about the work. While this was a turning point in the session, and was followed by increased openness, risking and sharing between members, concern about the exposure of practice, feelings and attitudes reemerged several times in the course of the group's development.

While much of the reluctance to risk within the group seemed to be related to the workers' preexisting and continuing relationships as colleagues, there was also anxiety about exposure to the leader and, thereby, to their administrators. The contract which was established at the first session emphasized confidentiality but concerns about trust persisted. For example, during the third session, considerable anger was expressed that the department's administrators did not provide sufficient support and rewards to workers. In reference to worker morale, one worker stated "things stink here." In the discussion which ensued, reference was made to the fact that the supervisors of four group members were both absent from the group that day. A worker wondered aloud

how open everyone would be about the same issues with the supervisors present. During a discussion of whether the supervisors would inhibit the group's ability to look critically at the lack of supports within the department, one worker comments jokingly, "Remember you're being taped!" Even in the final meeting such concern was revealed, again in relation to discussion of the administration and lack of understanding of the workers' experiences. A member joked that another was "talking low, but it's on the same tape recorder!" This was greeted by loud laughter from the rest. (The leader's response to the concern about trust and its relationship to the group contract is discussed later in the chapter.)

These incidents occurred in spite of assurances that the tapes would be exclusively for the investigator's use, and in spite of several reassurances from the workers that they knew this was so. Similarly, when group discussions were recorded in order to assess important areas of content, other researchers have noted silence and suspiciousness.⁵¹ Concerns about confidentiality were also related to the possibility of administrators learning of statements made in the group and "leaked" by the members. On one occasion a member reported that when a member of staff who was not in the group had asked about a topic discussed at a previous session, she had become aware of a "grapevine" in the department. She spoke of anxiety about the content of the group reaching

the administrators. Another worker spoke of the department's history of "gossip" and indirect communication but noted that the present group seemed to be free from such influences and a safe place to talk. Another example of concern about trust occurred during the final session when a worker recalled that she had worried that open and direct reports of practice "could be used against" workers. This was raised during a discussion of supervisory evaluation of workers, suggesting that the concern was related directly to the presence of supervisors in the group.

In addition to the presence of supervisors and the fact of the investigator tape recording all sessions, the group's ability to focus on its purpose and develop as a group was influenced by the history and culture of the department. Doubts expressed in the early sessions, about their ability to risk and share feelings openly, were related to the physical and social isolation of workers from each other. It was stated that the sharing which took place in the first two sessions of the program "was not the usual style of the department." In the fourth session there was a reference to the "immature" communication pattern of the department, whereby problems were suffered in silence -- the "lid" being on unless things became "desperate." The workers' isolation was highlighted by the statement that people still did not know each other after working for ten years in the same

place. One member questioned the value of changing that culture within the group if, after the program, everyone would revert to former patterns. What emerged as of paramount importance for the group was the lack of any prior experience of sharing practice, feelings and attitudes freely with colleagues in a group. The group demanded work from the members as well as offering them something. During the final meeting one member commented on differences from the previous group program undertaken in the department, which had been focused on learning group process: "This was different...in the other, he put it together for us...here it was for us to do it... and we did it!"

Leadership

Hare identifies functions common to leaders of all groups as advancing the group's purpose, administration of the activities, setting the pace, making individual members feel safe and acting without regard for one's own interest.⁵² He points out that the group's need for leadership depends on the culture in which it is operating, the personalities of the members and the actual characteristics of the leader.⁵³

In the model peer support group all of the above activities were undertaken by the leader but were modified by the group's intended development of peer leadership.

Functions of the Group Leader

Specific activities undertaken by the leader were as follows:

1. Facilitation of the Group Process

The primary task of the leader in this program was to develop a climate of comfort for the members so that the environmental factors already identified could be counterbalanced, freeing the members to participate with confidence. This was accomplished by a combination of techniques which included support and validation of contributions to the discussion, direct questioning to encourage participation, normalization and universalization of topics risked tentatively, and modeling of open communication. The leader shared examples of experiences as a worker with cancer patients and spoke of her own attitudes and feelings. For example, in the second meeting, one member described her coping pattern of withdrawing from patients and when reassured by other members that what she did was acceptable, the worker went on to state that rationalizing the situation often kept her from "falling apart." The leader spoke of her own experience as a new worker in an exclusively cancer-focused setting and then generalized to include the effects and coping patterns noted in other workers. This activity opened a group discussion of the variety of coping patterns used by workers, including withdrawal, avoidance and talking to colleagues for support, and prevented the

worker who had taken the initiative from standing alone in exposing the difficulties she experienced. When she spoke again, she referred in more detail to the fears which she experienced. As described earlier, a supervisor then helped to normalize the material shared, using a technique similar to that of the leader, and drawing in the rest of the group.

2. Development of Focus and Purpose

Other activities of the leader were directed to the development of group focus and purpose and included the proposal of a contract, the establishment of the norms of punctuality and confidentiality and purposeful connection of material to the group's central task.

In order to help the group re-focus, the leader used the following techniques. When natural breaks occurred in the process, such as occasional telephone interruptions or when a topic seemed to founder, the leader summarized the preceding discussion, highlighting themes and "unfinished business." Sometimes members' statements were reinterpreted by the leader in order to make their relation to the core theme clearer. For example, during the third meeting of the group, discussion focused on worker morale, the lack of adequate gratification from the job and dissatisfactions with office space. The discussion was animated, reflecting strong feelings. It appeared to be unrelated to the agreed

agenda of discussing feelings and stresses in work with cancer. The leader repeatedly drew connections between the lack of central office space and its effects of isolating staff and the already expressed gap in supports for work as emotionally stressful as their cancer work. Towards the close of the session, a member commented that there had been discussion of everything but cancer and continued, "The two things are linked; there's a sense of impotence." The sense of powerlessness which people experience with cancer epitomizes the patient's lack of control of illness. While social workers' goals are not to cure client's illnesses, they frequently become caught in the sense of impotence and failure experienced by the entire health team when a cure is not achieved.⁵⁴

The value of workers' contributions to the discussions was acknowledged by the leader in a variety of ways, including a summary of the themes of the previous meeting presented at the beginning of each session.

3. Identification of Obstacles

As the group moved through various states of development, the leader took primary responsibility for identification of obstacles such as lack of trust, resistance and hesitation. In order to help the group to come to grips with its task it was necessary at times to allow lengthy silences to occur as members reflected on their experiences in the group. The leader had to make

decisions about when to intervene or to point out the significance of silence at a particular point in the group process.

In addition to the aspects of leadership discussed above, which are inherent in any small group, the leader was present as a researcher with expertise in the specific area of concentration of the group. In this capacity, the leader provided information related to cancer, such as the prevalence of denial as a way of coping, history of other models of support, such as staff groups at Memorial Hospital, and data derived from the needs survey of the study, such as the range of methods reported for coping with job stress.

Interaction of the Leader's Role and Group Process

An analysis of the leader's activities and their consequences suggests that the presence and function of the leader was important for the development of a climate suitable for the establishment of peer support and mutual aid. Both the leader's subjective evaluation and that of the group members indicate that the group's progress was considerably aided by the leader's work in providing focus and identifying obstacles in the group. The leader's role was particularly valued for helping the group to break new ground in the department and for enabling the members to find a "unity of goals and problems," as one worker expressed it during the final meet-

ing. The members of the group also saw themselves as ready to try to function as a leaderless group.

Some doubts were expressed about the consequences of not having a leader to hold the group together, but the group's feeling of unity and of having "been through something together" prevailed and the continuing program was launched.

At different stages of the group's development there was considerable dependence on the leader. When the group began there were requests that a focus be provided by the leader. This was more strongly developed later when the hasty intimacy of the early sessions waned and the group turned to the leader to reestablish the focus of the program. At the end of the group, along with the assertion of independence inherent in planning a continuing program, the group was eager for evaluation from the perspective of the leader. One member asked if the group had turned out as the leader had hoped and called for absolute silent attention from all members as the leader prepared to respond.

Independence from the leader and ability to function as a group of peers was evident at those times when workers questioned or challenged the leader or asserted their own needs and preferences in relation to the group's focus and content. Members had a sense of having accomplished something together. They did not discount the value of a leader, but they valued their own roles as

peers. One worker made the following statement in the last meeting:

We did our work, for us, not for someone else. The leader structured the group, but we didn't have to do much to gain her acceptance or approval. It was different from presenting yourself in someone else's framework. It flowed; it was allowed to flow; or we made it flow. I don't know which one -- or all of them.

The leader's experience in the group also demonstrated the interrelationship of the many elements of the group process. Although entering the group as an experienced practitioner, aware of the typical patterns of group development, the leader was influenced in the administrative role of leader and pacesetter by the tremendous enthusiasm for a support group which developed in the first few meetings. As a result, the group was helped to move forward very rapidly and with a hastily agreed contract, which guaranteed confidentiality on the part of the leader but which initially omitted reference to expectations for confidentiality of members. While some members stated that they had understood the norm to extend to all present, the leader's analysis of the process when the group became readily intimate and then withdrew, suggested the need for renegotiation of the contract with clarity in respect to trust and confidentiality.

The demand on members for activity in developing the group as a peer support group was a unique and difficult experience to undertake. The mistrust evident in

the group was derived from a lack of trust in each other, the internal reputation of the department for "gossip" and the compositional mix of line staff and supervisors, as well as an unknown and untested leader. This is comparable to the experience of social workers in a training program described by Gelfand and others.⁵⁵ The workers were unaccustomed, within their agency, to the use of group process or to taking responsibility for their own learning. Trainers found that mistrust and resistance were obstacles to learning until trust in the trainers was established.⁵⁶

In the peer support program, mistrust and resistance took a variety of forms of expression, including great dependence on the leader to direct the focus and provide content. As described above, the process of development enabled members to overcome the resistance and establish a peer support program. One illuminating aspect of the process was the pressure on the leader to be very active, at least in the first half of the program. In analyzing the process and the leader's participation, it was observed that at times the pressure and expectations caused the leader to talk more than was the intended style and practice. This experience supports Hare's contention, discussed above, that the specific characteristics of the leadership role are influenced by a variety of factors, including the group's culture and the influence of members of the group.⁵⁷

Mutual Aid

The development of mutual aid was the expressed purpose of the group but, as the preceding analysis of the group's development indicates, there were obstacles to be overcome in order for the members to involve themselves in an active process of mutual aid and support. The process involved the discovery of unity of purpose and interests, the exposure of commonality of experiences, feelings and concerns and the growth of an atmosphere of trust.⁵⁸ Although there were instances of support and mutual aid from the beginning of the program, the frequency of their occurrence increased as the group reached a stage of intimacy and cooperation.⁵⁹

The support and aid which were offered took many forms. An analysis of the types of aid is presented, with examples drawn from the full time-span of the program. There was evidence that the workers experienced the group's work as supportive and helpful. They chose to continue as a peer support program because they felt that they had made important gains in the group. In the final session, one member said of the group, "The specialness was the sharing. There were little suggestions, but it was less education or about practice than learning to share and support. That's what I would want to continue." The impact of the group also extended to practice outside. One of the supervisors stated that after being in the group for a while, she had shared personal

reactions with a supervisee who was a group member, in a way that she would not normally share.

Elements of Mutual Aid

1. Providing Information

The provision of information which others may use is a basic component of the mutual aid process. Members of the group shared a fundamental knowledge base of work with cancer patients but each had specialized knowledge in areas related to their specific assignments. One of the workers on the gynecology service talked about the changing experience of patients with ovarian cancer; the worker on the head and neck service gave information about the ways that her patients were affected by their disease and the pediatrics worker gave information about children's cancer and provided a reference to helpful literature.

2. Offering Examples, Suggestions and Advice

Support and mutual aid were also provided through members' illustrative examples of ways in which they managed stress and through suggestions and advice for coping with varied aspects of the job. An example of mutual aid occurred in the seventh group meeting when members exchanged suggestions for separating from the job at the end of the day and unwinding from job stresses. Excerpts from the discussion illustrate the atmosphere

of interchange of ideas.

- A. "I tend to be very quiet. My husband prods me to talk, and he is someone I can talk to, but my mood changes. Sometimes I cannot talk about what's bothering me."
- B. "I don't take work home with me."
- C. "I like to leave it all at work and be able to return fresh the next day."
- A. "But don't you worry about things that happened at work that day?"
- B. "I certainly used to. I would dream about my work."
- D. "I came back to work at eight in the evening once because I was worried about someone. But I don't do it any more."
- A. "I had a dream of an interview with a client of mine. And it was a good interview. I did well. I must have been anxious about my work with that client."

Further discussion ensued, moving from description of varied ways of coping to recommendations that might add another dimension to each worker's management of stress.

- F. "You need things to look forward to, things to enjoy to balance the perspective...."

Other workers picked up the theme:

- A. "Physical exertion is good. It's comforting to work out at a gym or something."

Other suggestions included an activity like singing, because it requires concentration on the activity itself, or entertaining friends.⁶⁰

During another meeting, members discussed the importance of peers as a source of support on the job.

One member gave an example of a very difficult case situation involving a stressful piece of interprofessional work. She stated that she had been distressed, and emphasized that she had talked about it to another worker and obtained support and encouragement to move on.

3. Seeking Help

The mutual aid process was furthered by the ability of the members to seek help from one another. At a point in the fifth meeting, a member described feeling pressured when colleagues criticized her plans for transfer of a patient to a nursing home. Another worker asked directly how she had dealt with it. The worker gave a straightforward answer, describing what she had done and highlighting the problems of becoming identified with patients.

In another discussion, one member referred to belief in reincarnation. Another member asked "Does that help when your patients are dying? Does it make your work easier?" The worker's reply and description of the value of the belief system led to other members identifying their use of religious beliefs as coping mechanisms. One gave the example of having recently tried to talk to a priest at lunch-time because the morning on the job had been so depressing and focused on death.

4. Encouragement and Reassurance

Members encouraged each other to be active in the group and to share examples and concerns with one another. An example of the process of encouragement is illustrated by the response to a member who tentatively introduced a new topic. Another worker said, "Go on, you started to talk about something that may be important to all of us," and this response was supported by others who expressed interest in the theme. The member who gave the initial encouragement made similar interventions on other occasions. In the final session, a member talked about the value of the group and interest in maintaining it. The response of the supporting worker was, "You said that well!"

During the sixth session a member asked for the group's help in dealing with very depressed feelings about the current workload. In the course of the supportive discussion which took place, a member spoke of similarly troubled feelings and some ways of coping. The worker seeking help expressed thanks and said, "Today I crashed. I'm not sure why. I regressed to how I was at the beginning with cancer patients."

Another worker responded that such moments of feeling overwhelmed were normal and the theme was quickly picked up by others who reassured the troubled worker that the same was true for them. At the end of that meeting, the worker who had asked for help was thanked for

opening up the topic.

5. Validation, Normalization and Universalization

As the group developed and members ventured to expose their personal stresses in relation to the job, there was considerable support through validation that others shared the experience or feeling. On one occasion, the male worker stated that when stress accumulated for him he felt miserable but that "it's harder for me to cry than for many of you. I go to a sad movie and bawl." Another worker responded at once, "It's hard for me to cry too." Others joined in, some also stating that crying was difficult and others that it was a release of feelings that came readily.

During the second meeting of the group, one worker stated that her pattern of coping by withdrawing and denying any relevance to her personally was not an acceptable way of dealing with the stresses of the job. She described what she did as "terrible." Other members responded, in chorus, that it was not terrible, thereby normalizing the reported feelings and behavior. On another occasion, a member spoke of feelings of guilt when service to a cancer patient was not of good quality because the worker was already drained by other difficult cases of the same type. Another member responded, "That's natural. It happens to everybody."

The universalization of experiences and feelings which began in the initial sessions of the group enabled workers to feel comfortable expressing their concerns in the group and gave them a new perspective on their stresses and patterns of coping. This was made clear in the fourth session when a member said, "I left last week feeling great. I never knew before that everyone had cancer phobia."

Another aspect of the process of normalizing experiences and feelings which was helpful to the members was the mutual acceptance of differences. This was particularly evident in the sixth meeting, when workers discussed differences in their ability to distance themselves from clients and different philosophies in relation to involvement with clients. Workers spoke of their identification with clients. One member said that it was "very destructive, in a way, to allow ourselves to be so hurt...." Another said that it could not always be prevented and a third member pointed out the need to recognize differences in style and accept them. Later in the meeting, another worker said how much she had learned from the discussion, and spoke more of her own coping style. She added that if she did not protect herself by distancing she would "probably die."

6. Cooperative Planning

An important final category of mutual aid which developed in the group was the work of planning together for an ongoing program. The process was initiated in the fourth session when a member who frequently introduced new topics and helped to move the group forward, asked the leader for help in the establishment of a self-help group for the workers. Other members picked up the idea immediately and tested out suggestions for the type of group that might be possible. This collaborative work involved reconciliation of different interests and required the committed interest of at least a majority of the members.

As the group developed, sufficient trust and commonality of interest emerged for the members to actively work on plans for a continuing program. In the final session, a worker stated that the group had come to trust, listen to, and get to know each other. This opened a discussion of continuing needs which culminated in specific planning. One member moved the process forward when she said, "How do you set it up? Let's get practical." Others responded with specific suggestions and by the close of the program, the first continuation meeting was scheduled. A variety of techniques enabled the workers to develop the support and mutual aid patterns of the group. The role of the leader in modeling and proposing peer support has been reviewed. The

members were active as listeners and almost without exception took initiative in both seeking and offering forms of help. Some of this work was accomplished with the use of humor, as members laughed at themselves and enjoyed the recognition that others experienced such similar stresses. There was also commitment to gaining something from the group, and this motivated members to actively work to overcome obstacles to the mutual aid process.

CHAPTER III FOOTNOTES

¹Alex Gitterman, "Development of Group Services," in Conference Proceedings on Social Work with Groups in Maternal and Child Health (New York: n.p., 1979), pp. 15-21.

²Dorwin Cartwright and Alvin Zander, Group Dynamics (New York: Harper and Row, 1968), p. 488.

³Decentralized social work offices have long been recommended. See Sidney Hirsch and Abe Lurie, "Establishing a Hospital Social Service Department," Social Work 4:2 (April 1959), pp. 86-99. They state that:

In general, social work staff should be housed where the treating personnel is located. The office of the director of social service, together with those of the supervisors, clerical staff and intake, may be located in one area as the "main office" and should be centrally located.

As support for this recommendation, they cite A Statement of Standards to be Met by Social Service Departments in Hospitals, Clinics and Sanatoria. (Washington, D.C.: American Association of Medical Social Workers, 1949), p. 8.

⁴Supervision in social work has three complementary functions--administrative, educative and supportive. The supportive function is always balanced against the evaluatory role of the supervisor, which may be a barrier to the establishment of mutual trust.

⁵For a discussion of various administrative structures in social work departments, see Sidney Hirsch and Lawrence C. Shulman, "Participatory Governance: A Model for Shared Decision Making," Social Work in Health Care 1:4 (Summer 1976), pp. 433-446. The structure of the East End Hospital department is representative of many similar social work departments.

⁶See Chapter II, note 20.

⁷The needs survey of this study had suggested that younger, less experienced workers would be the most likely participants, although some older and experienced staff had also requested a support program. The mix of

line workers and supervisors was not the investigator's preference, since the possibility of inhibited participation was clear. However, since this was the available group, the program proceeded with the investigator paying careful attention to the influence of the supervisory relationship on program participation.

⁸Malcolm S. Knowles, "Innovations in Teaching Styles and Approaches Based Upon Adult Learning," Journal of Education for Social Work 8 (Spring 1972), pp. 32-39.

⁹Margaret E. Hartford, Groups in Social Work (New York: Columbia University Press, 1971), p. 61.

¹⁰Ibid.

¹¹Gitterman, op. cit.

¹²Hartford, op. cit. Although this framework is not explicated, it is implicit in the text, with each of the elements as a separate chapter heading.

¹³Helen Northen, Social Work with Groups (New York: Columbia University Press, 1969).

¹⁴Alexander Hare, Handbook of Small Group Research (New York: Free Press of Glencoe, 1962), p. 1.

¹⁵Hare, op. cit.

¹⁶See James A. Garland, Hubert E. Jones and Ralph Kolodny, "A Model for Stages of Development in Social Work Groups," in Explorations in Group Work: Essays in Theory and Practice, ed. Saul Bernstein (Boston: Boston University School of Social Work, 1965), pp. 12-53; and Bruce W. Tuckman, "Developmental Sequence in Small Groups," Psychological Bulletin, LXIII (1965). For a recent example of analysis based on developmental phases, see Daniel Katz, "Preparing Public Agency Field Instructors" (D.S.W. dissertation, City University of New York, 1982). Katz placed all study group activities within four categories to provide a means of analyzing relative importance and dominance of types of activity.

¹⁷See Robert F. Bales, Interaction Process Analysis (Reading, Mass.: Addison-Wesley Publishing Co. Inc., 1950).

¹⁸Arthur M. Cohen and R. Douglas Smith, The Critical Incident in Growth Groups (California: University Associates Inc., 1976); and John C. Flanagan, "The Crit-

ical Incident Technique," Psychological Bulletin LI, 4 (1954), pp. 327-358.

¹⁹Tuckman, op. cit.

²⁰Ibid.

²¹The personalities of participants clearly affected their group participation. There were talkers and listeners, initiators and followers and outspoken and cautious members. Nonetheless, the group process was important precisely for its qualities as a group and, in contrast to a therapy group or T-group, was not directed towards highlighting or changing the behavior of any individual.

²²Gerald P. Koocher, "Adjustment and Coping Strategies Among the Caretakers of Cancer Patients," Social Work in Health Care 5:2 (Winter 1979), pp. 145-150.

²³Koocher, op. cit., pp. 148-150.

²⁴Ibid.

²⁵All oncology patients at East End Hospital are receiving chemotherapy as part of research protocols. For a discussion of hospital procedures and medical research, see Clara Joan Milner, "Compassionate Care for the Dying Person," Health and Social Work 5:2 (May 1980), pp. 5-10.

²⁶Marion F. Stonberg, "Oncology," Health and Social Work Supplement to Vol. 6:4 (November 1981), pp. 695-745.

²⁷For a comparison of care in hospitals and specialized hospice care, see Nina Millett, "Hospice: Challenging Society's Approach to Death," Health and Social Work 4:1 (February 1979), pp. 130-150.

²⁸The needs survey of this study revealed variation in the number of patient deaths experienced. One third of respondents reported that 10% or fewer of their patients died, while for an equal number, more than 30% died, and for more than half of that group, the percentage was as high as 70-100%. Typically, social workers on surgical services will see patients whose cancers are operable and, in many cases, recently diagnosed. Those on medical services often see patients for whom surgery has not been appropriate or successful and those suffering from the spread or recurrence of the disease. On all services, patients with poor prognoses are referred to social workers for multiple services.

²⁹Such support is strongly recommended to prevent burnout. See, for example, Ayala Pines and Ditsa Kafry, "Occupational Tedium in the Social Services," Social Work 23:6 (November 1978), pp. 499-507.

³⁰For a discussion of divergent views of the role and function of hospital social work, see Katherine M. Olsen and Marvin E. Olsen, "Role Expectations and Perceptions for Social Workers in Medical Settings," Social Work 12:3 (July 1967), pp. 70-78.

³¹Nina Toren, "Semi-professionalism and Social Work - A Theoretical Perspective," in Amitai Etzioni, ed., The Semi-professions and Their Organization (New York: Free Press, 1969), p. 184.

³²Charles Levy, Social Work Ethics (New York: Human Sciences Press, 1975), p. 166.

³³Such professional conflicts are identified in Doran Teague "Social Service Enterprises: A New Health Care Model," Social Work 16:3 (July 1971), pp. 66-74.

³⁴There is no formal interdisciplinary forum for discussion of cancer or death in East End Hospital.

³⁵The Oncology Network is an organization of social workers in oncology in New York City.

³⁶A national organization of pediatric social workers who work with cancer patients.

³⁷"The supervisory situation generates a number of different kinds of anxieties for the supervisee." Alfred Kadushin, "Games People Play in Supervision," Social Work 13:3 (July 1968), p. 23.

³⁸See discussion of developmental stages later in this chapter.

³⁹Ibid.

⁴⁰See Garland, Jones and Kolodny, op. cit.; Northen, op. cit.; and Tuckman, op. cit.

⁴¹Garland, Jones and Kolodny, op. cit.

⁴²In the conceptualization of Garland, Jones and Kolodny, the second stage of group development is "power and control."

⁴³Garland, Jones and Kolodny, op. cit., p. 29.

⁴⁴A program of eight sessions was developed to conform to the in-service training program at East End Hospital.

⁴⁵Garland, Jones and Kolodny, op. cit.

⁴⁶Tuckman, op. cit.

⁴⁷Separation is the fifth stage in the schema of Garland, Jones and Kolodny and the fifth, or "termination" stage in Northen's conceptualization. In Tuckman's terms, the last of four group phases is "Performing" with no separate category for the end of the group.

⁴⁸The behavior described here is congruent with the stages of development described above.

⁴⁹Teamwork and collaboration between doctors and social workers is frequently only approximated. For a discussion of the difficulties of collaboration in relation to discharge planning, see Kay Wallis Davidson, "Evolving Social Work Roles in Health Care: The Care of Discharge Planning," Social Work in Health Care 4:1 (Fall 1978), pp. 43-54. For a more general discussion of collaboration, see Hyman J. Weiner, "Communications Among the Professional Team," in Social Work in Maternal and Child Health: A Casebook (New York: Columbia University School of Social Work and St. Luke's-Roosevelt Hospital Center, Department of Social Work, Roosevelt Division, n.d.), pp. 1-11.

⁵⁰Garland, Jones and Kolodny, op. cit.

⁵¹Robert Gosling et al., The Use of Small Groups in Training (London: Grune and Stratton Inc., n.d.), pp. 104-109.

⁵²Hare, op. cit., p. 293.

⁵³Ibid., p. 320.

⁵⁴Koocher, op. cit., p. 147.

⁵⁵Bernard Gelfand et al., "An Andragogical Application to the Training of Social Workers," Journal of Education for Social Work 11 (Fall 1975), pp. 55-61.

⁵⁶Ibid., pp. 57-58.

⁵⁷Hare, op. cit., p. 320.

⁵⁸For a discussion of the difficulties of creating a mutual aid group, see Lawrence Shulman, The Skills of Helping Individuals and Groups (Itasca, Ill.: Peacock Publishers, Inc., 1979), p. 110.

⁵⁹Shulman, op. cit., p. 112.

⁶⁰For suggestions of coping strategies, see, for example, Robert Kahn, "Job Burnout: Prevention and Remedies," Public Welfare 36 (Spring 1978), pp. 61-63.

CHAPTER IV

EVALUATION

Introduction

This chapter will review the evaluation process undertaken as part of the project, reporting on the evaluation design and subsequent findings.

As appropriate to an exploratory project, the evaluation design was essentially formative.¹ The evaluation strategy took the form of a case-study which provided a detailed description of the program's development, employing primarily qualitative data in an effort to describe the project's progress and develop new ideas about peer support.²

The primary emphasis of the evaluation was the monitoring and assessment of a group designed to establish peer support and mutual aid between members. This was considered appropriate to the project's goal of generating new knowledge about the specific nature of the stresses experienced by social workers working with cancer patients, the components of support as developed in the program and the workers' interest in and ability to develop a peer-based support system.

Secondarily, the evaluation assessed the outcome of the program in terms of its effects on the participants. In the design of the project, it was hypothesized that the support program would have a positive impact on the ability of participants to cope with job stresses related to cancer. It was anticipated that such changes in coping ability would be reflected in the participants' feelings and attitudes related to their work with cancer patients as well as in specific behaviors. The outcome component of the evaluation, therefore, sought to establish changes in coping ability of the participants which resulted from the program. The evaluation's primary focus on the process of the program insured that data on changes reported by participants were "supplemented by intensive qualitative analysis of the events of the program in an attempt to understand the relationships between program services and participant progress."³

As part of the evaluation there was a participant assessment of the program's effectiveness in meeting its goals.

Finally, unanticipated effects of the program on the participants, their colleagues and patients and the group leader were assessed. Following Weiss's recommendation, the investigator sought to "keep an eye on the 'other' consequences of the program."⁴ The evaluation took into account the possibility that program

effects could spill over into other areas of the participants' life and work and that, in addition, the presence and success of the group program could have effects on the social work department as a whole.

The Group Process

Evaluation of the program's success in meeting the goal of establishing a group for peer support and mutual aid is based on the analysis of the group's themes and progress reported in Chapter III. Two aspects were evaluated:

- 1) The extent to which the program succeeded in reaching its intended participants
- 2) The development of peer support and mutual aid

Program Contact

The impact of any program must first be considered in terms of the extent to which the intended content of the program was actually received by the desired participants. As stated by Tripodi, Fellin and Epstein, "The goals of the contact stage are concerned with the bringing together of program content and clientele."⁵

For this project, it was important to assess if the program succeeded in recruiting the sample population intended and if it implemented the planned service and engaged participants' active and regular involvement. Suchman, noting that one criterion for evaluating the

success of any program is that of "effort", states that "it indicates that something is being done in an attempt to meet a problem. Certainly, this is a necessary, if not, sufficient condition for accomplishment."⁶ In order to assess the strength of the independent variable, the number of sessions of the program and the actual attendance of participants were counted. Measures such as attendance records and logs of content themes which reflect adherence to the project plan were supplemented by judgments of the receptivity of the participants.⁷

Data relating to attendance, as reported in Chapter III, indicated that all but one member attended at least six of the nine sessions of the program and that eight members attended seven or more sessions. A high level of active participation by all members,⁸ including the worker who attended only four sessions, indicated strong interest and involvement in the program's content. Relevance of the content and evidence of its favorable reception by the members were further demonstrated by their interest in continuing to meet as a peer support group after the project's termination.

These data suggested that there was sufficient contact between the program and its participants to satisfactorily test its effectiveness.

Development of Peer Support and Mutual Aid

The preceeding analysis of the content themes of the group and its development provided the basis for assessment of the extent to which the project had achieved its goals of establishing a peer support mechanism for the members and developing a system of mutual aid. (See Chapter III.)

Two indicators provided measures of the program's success in establishing a peer support group. Both analysis of discussion content provided by tape-recordings and logs of the group sessions as well as documentation of the decision to continue indefinitely as a support group offered solid evidence that the program goal was to a great extent achieved.

The program's success in mobilizing forces for mutual aid was assessed primarily by analysis of the group process and by documentation of instances of mutual aid which occurred during group sessions. The investigator's assessment that a substantial degree of mutual aid occurred is supported by the analysis of the mutual aid process presented in Chapter III. (See pp. 158-166.) It was found that members offered each other information, advice and encouragement from the beginning of the program. As the extensive literature on burnout documents, workers experiencing emotional stress characteristically turn "to other professionals for advice, comfort, ten-

sion reduction, help in achieving distance from the situation or intellectualizing it, and a diffusion of responsibility."⁹ The investigator's observations of spontaneous occurrences of mutual aid within group sessions seemed to indicate an increase through the course of the program.

The achievement of mutual aid was also perceived by participants, and is reflected in their evaluations of the program which are analyzed later in this chapter. Some examples of comments related to the positive experience of mutual aid that developed in the group and were evident on every evaluation questionnaire are as follows: One member noted that the best experience provided by the group was that of "teamwork." Another highlighted the experience of "giving and taking support." The assessment of the mutual aid process was further confirmed by the reports of group members that their help to each other had been extended beyond the meetings of the group. They reported instances of seeking and offering help to each other around case situations and stated that this would not have occurred prior to the program.

There was additional evidence that the program was experienced by the members as supportive. Such support was increasingly derived from peers as, in the development of the program, the participants themselves became more active and vocal. By the time of the seventh meeting, the members had begun to perceive the value of

the group as a means of support. This became evident in a discussion of coping, when members commented as follows: "I think something like this (the group) helps ...you hear how other people cope, and that's important. Sometimes you forget what other people are going through. Something like this helps." Another added that all members were "equals here and all have the same kinds of feelings. With peer support, everybody's equal and all have similar emotions." Another member noted a somewhat different facet of peer support, commenting that in a group "you get variations...you hear so many people and you can take a piece that helps you with your work."

This discussion exemplified the members' reports that the group program provided them with peer support relevant to their job stresses and that such support was valued as separate and different from help obtained in supervision.¹⁰ The consequent assessment that the project had succeeded in its goals related to peer support was further supported by the participants' written evaluations of the program's effectiveness.

In evaluating the program after its completion, members all reported that they were involved in planning the group's continuation as a support group in the department. This gave implicit recognition to the value of the group as a support system. Most members also made explicit reference to the value of peer support when they responded to open-ended questions such as those

about the program's effects on coping. An example of a comment on aspects of the program that had increased coping ability is the statement, "The realization that other workers share common problems and feelings makes me much more able to cope with the day-to-day stresses." Another response stated that coping was aided by "knowing that many feel the same way I do, and knowing I have support from others in the department (group)."

These data provide evidence both from the investigator's records and from participants' evaluations that the project's goal of developing a model program for peer support and mutual aid were substantially achieved.

Outcome Measures

As stated earlier, the ultimate desired outcome of the project was the improvement of service to cancer patients. The more immediate goal of the program, presumably linked to the ultimate goal, was that of improving coping ability of the participants. As Weiss states,

Often the best that evaluation can do, at least under the usual time constraints and in the absence of better knowledge, is accept the program's assumptions and find out how well near-term goals are being met. It is left to further research to explore the relationships between short-term goals and long-term consequences.¹¹

Specific outcomes desired for the project were the development of support and mutual aid, improved coping ability of participants and reduction of the stress experienced in their work with cancer patients. The

evaluation of the support and mutual aid process, as presented above, was based on analysis of group content themes and on participants' program evaluations. The outcome component of the project focused not on the support and mutual aid process but on changes in the participants' experiences of stress and satisfaction in relation to their work and in the methods that they used to cope with the work. The impact of the program was evaluated by assessing changes in workers' self-reported attitudes, behaviors and feelings in relation to their work with cancer patients, by examining changes in their perceptions of their most serious problems and by identifying effects on work behavior.

Because of the project's time constraints, effects of the program were evaluated only once, two months after the program's termination. Ideally, such testing would be repeated later to see whether positive effects persist over time.¹²

An identical test was administered before and after program participation, using an instrument designed to measure changes in attitudes, behaviors and feelings about cancer and the stress of the work. (See Appendix 4.) The data collected in relation to attitudes, behaviors and feelings are presented in tabular form to facilitate assessment of differences between responses at the initiation of the group program and after its termination. (See Tables 9, 10 and 11.) However,

this exploration was undertaken to reflect changes related to the study's central concepts of stress and coping. Therefore, for analysis and evaluation, the data were reorganized and presented below in relation to work stress/satisfaction and coping, with each category incorporating several dimensions of attitudes, behaviors and feelings. The following trends, which were reflected in the findings, can only be viewed as suggestive because of the small numbers in the sample.

Work Stresses and Satisfactions

Eight dimensions of participants' experiences of stress and/or satisfaction with their work with cancer patients were explored. They focused on satisfaction; stress; belief that the job had special requirements; sense of competence or helplessness; degree of identification with clients; apprehension; depression and desire to change assignment.

1. Work Satisfaction

As shown in Table 9, both before and after the program, work with cancer patients was regarded as satisfying, although demanding. At the posttest, there was increased agreement that such work was satisfying. On another dimension of satisfaction, also illustrated in Table 9, that of finding many opportunities to help, no change was evident.

TABLE 9

COMPARISON OF QUESTIONNAIRE RESPONSES BEFORE
AND AFTER THE PROGRAM: ATTITUDES

	Strongly Agree		Agree		Disagree		Strongly Disagree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1. Harder to see cancer patients than others		1	4	5	5	3		1
2. Problems of cancer patients more complex	1		3	6	6	3		1
3. Work satisfying, although demanding	1	3	8	6	1			
4. Many opportunities to help			8	8	2	2		
5. Difficult to set realistic goals			1	3	8	4	1	3
6. More stressful than other work	1	1	5	7	4	1		1
7. Requires special knowledge and skills	2	3	5	3	3	4		
8. Most people at work don't want to talk about cancer			4	4	3	4	3	2

TABLE 9--Continued

	Strongly Agree		Agree		Disagree		Strongly Disagree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
9. May need to turn off feelings at the end of the day		1	7	6	3	3		
10. Feelings such as wanting to avoid patients are best kept to oneself					7	6	3	4
11. Helpful to talk to someone when work is upsetting	8	8	2	2				
12. Possible to work as well with cancer patients as others	5	6	5	3		1		

TABLE 10

COMPARISON OF QUESTIONNAIRE RESPONSES BEFORE
AND AFTER THE PROGRAM: BEHAVIORS

	Always		Often		Sometimes		Rarely		Never	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1. See cancer patients less often					4	4	5	6	1	
2. Interviews with cancer patients shorter			1		1		6	9	2	
3. See dying patient less often or more briefly			1		5	8	3	1		
4. Talk to colleague when case depressing		1	3	1	7	8				
5. Seek supervision for difficulties about cancer			3		4	6	3	3		1
6. Support from colleagues in other areas	1		4	6	5	4				

TABLE 10--Continued

	Always		Often		Sometimes		Rarely		Never	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
7. Focus on other areas when many pressures from cancer work			2	2	4	5	4	3		
8. Seek information about patient's cancer	4	5	3	4	2	1	1			
9. Look for programs about cancer	3		3	6	3	3	1	1		
10. When troubled about case, talk to friends outside job			1		3	4	5	6	1	
11. Keep feelings about dropping case to self			1	2	3	3	5	5	1	

TABLE 10--Continued

	Always		Often		Sometimes		Rarely		Never	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
12. Able to listen and concentrate with cancer patients	3	5	6	5	1					
13. More exhaustion with cancer patients	1	1	4	4	4	4	1	1		
14. Trouble viewing cancer patients as individuals					3	1	5	7	2	2

TABLE 11

COMPARISON OF QUESTIONNAIRE RESPONSES BEFORE
AND AFTER THE PROGRAM: FEELINGS

	Always		Often		Sometimes		Rarely		Never	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1. Feel work valuable even when patient dies	3	3	3	2	1	1	2	3	1	1
2. Depressed when patients die		1	2	1	6	8	2			
3. Helplessness to intervene because problems complex				1	7	4	2	3	1	2
4. When most work with cancer, feel drained		3	7	2	1	4	2	1		
5. Complex needs lead to feeling help- less				1	5	4	4	5	1	

TABLE 11--Continued

	Always		Often		Sometimes		Rarely		Never	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
6. Identify strongly with some cancer patients			3		5	8	2	2		
7. Wish to change to assignment with fewer cancer patients			1		4	5	3	4	2	1
8. Feel someone else could do job better					4	2	4	7	2	1
9. Feel too involved with cancer patients				1	8	3	1	5	1	1
10. Feel relaxed and at ease with cancer patients			5	6	4	3	1	1		

TABLE 11--Continued

	Always		Often		Sometimes		Rarely		Never	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
11. Feel capable of helping cancer patients	1	1	5	9	4					
12. More apprehensive about meeting cancer patients				2	5	3	4	4	1	1

2. Stress

Table 9 illustrates that after the program more participants perceived the cancer component of the job as more stressful than other aspects, and more found it harder to go to see cancer patients than others. The single participant who had not perceived the work as particularly stressful and who did not find it harder to visit cancer patients than others moved at the posttest to strong disagreement about such stress.

Overall, the findings on work satisfaction and stress suggest an increase in perceptions of cancer work as satisfying although there was a slight concurrent increase in perception of the work as stressful.

3. Special Requirements of the Job

Table 9 illustrates that at the posttest, participants reported increased agreement with the view that cancer patients have more complex problems than others. Similarly, there was an increase in perceptions of difficulty in setting realistic goals with cancer patients. Although a concurrent change in the attitude that cancer work requires specialized knowledge and skills might be anticipated, the findings were less clear. At the posttest more participants disagreed that special skills are needed but one more worker reported strong agreement that special skills are needed. A comparable response occurred on the attitude that the poten-

tial exists for equally good work with cancer patients as others, with slight changes in opposing directions.

4. Helplessness/Competence

In facing the complexity of cancer patients' problems, workers experienced feelings of helplessness. As shown in Table 11, after the program there was a decrease in the frequency of such feelings, with a slight shift towards experiencing such feelings "rarely" or "never." At the posttest, fewer workers felt that others could do their job better and a parallel shift occurred in reports of feelings of competence, such that all participants reported "often" or "always" feeling capable of doing the job.

5. Identification

As shown in Table 11, after the program, fewer workers reported "often" identifying strongly with cancer patients. A comparable change occurred in feelings of over-identification. Table 10 demonstrates a decrease in those who reported feeling over-involved such that, by the posttest, most workers reported having such feelings "rarely" or "never."

These findings suggest that workers began to reduce feelings of identification and presumably over-involvement. It is not known whether this resulted from changes in ways of relating to clients or an increased tolerance for the painful feelings associated with a high

level of identification with clients.

6. Apprehension

Findings on this aspect are inconclusive.

Table 11 illustrates a slight increase from the pretest to posttest in apprehensiveness about meeting cancer patients but also a slight increase in feeling "relaxed" when with cancer patients. Since increased apprehensiveness seems incongruent with members' reports at group sessions, it is unclear whether the increase represents greater anxiety about the work or reflects greater recognition and self-awareness as a result of experiences in the program.

7. Depression

As Table 11 illustrates, the frequency of experiencing depression when clients died increased after the program. This finding raises the question of whether the extent of depression increased or whether workers became more aware of the feelings generated by their work and more ready to express them, as is suggested by their comments in evaluating the program.

8. Desire to Change Assignment

There was little change reported in feelings about retaining assignments. As Table 11 illustrates, most responses both before and after the program fell into the "sometimes" and "rarely" categories. The

measures did not reflect strong feelings such as those which might influence the actual change of assignment made by one worker.

Coping

Participants' responses reflected a variety of ways of coping with stress. Three areas of coping behavior were explored; withdrawal from patients, seeking support and seeking educational and informational opportunities. In addition, the sources of coping behavior were evaluated by exploration of the participants' experience of fatigue and ability to concentrate.

1. Withdrawal from Patients

Table 10 demonstrates changes in behaviors related to direct contact with cancer patients, especially if dying. There was a slight change in diverting efforts to other work when pressures of work with a cancer patient became excessive, a behavior used by most of the participants at least "sometimes." There were comparable changes in regard to decreased frequency and length of interviews with cancer patients. Whereas prior to the program most workers rarely or never saw cancer patients less often or more briefly than others, after the program the response "never" did not occur. In describing behavior with dying patients, responses were mixed. There were shifts both in increase and decrease of such behavior.

2. Seeking Support

Both before and after the program, all participants disagreed that feelings of wanting to avoid patients should be kept to oneself, and all agreed that talking to others can be helpful. There was also no change in the perception that most people do not want to talk about cancer patients. As Table 10 illustrates, all workers sought support from colleagues prior to the program. The slight decrease in the use of such support reported after the program may be attributed to the nature of the group and the discovery of sources of social work peer support. Indeed, concerning colleagues (unfortunately an ill-defined term) findings are inconclusive, since shifts occur in both directions, with some reporting less frequent use after the program and some more frequent. Use of friends outside work was a source of support reported only moderately by all respondents. Changes after the program were very slight, as illustrated in Table 10. The lack of use of friends may be related to the typical response that feelings might have to be turned off at the end of the work day. After the program, there was a slight change in this area, with one case of "strong agreement." (See Table 9.)

Overall, the responses suggested that withdrawal was used prior to the program and continued to be used afterwards. At neither time did it appear to be a dominant form of coping behavior. The typical response was

"sometimes," and became more centered on "sometimes" after the program, as more extreme responses of both "often" and "rarely" disappeared.

Use of supervisory support was less often reported at the posttest. Whereas at the pretest most respondents reported "sometimes" or "often" using supervisory help for difficulties in cancer work, after the program there was a shift to reduced frequency of such use. This finding suggested that the group program might replace some needs formerly met by supervision and enable members to substitute peer support. Respondents also indicated a limited use of supervisory support to help with feelings of depression, anxiety or wanting to drop a case. After the program there was a slight increase in the frequency reported of keeping such feelings to oneself. Since the findings in this area appear to contradict respondents' oral reports that they used such support, the possibility must be considered that this behavior, since it included the wish to drop a case, might be perceived as too negative to be exposed. A slight increase after the program in "keeping feelings to oneself" could also be interpreted to indicate that workers found themselves better able to handle such feelings unaided.

3. Seeking Education and Information Opportunities

As illustrated in Table 10, after the program more respondents reported seeking information about the specific illness of a cancer patient. In contrast, fewer respondents reported seeking to attend programs about cancer at the posttest. This suggested the possibility that the group program might serve as an alternative to such programs and dilute interest in other opportunities, at least temporarily.

4. Fatigue and Ability to Concentrate

Reports of the experience of fatigue and exhaustion did not change at the posttest. As Table 10 illustrates, most workers consistently reported that they often or sometimes experienced greater fatigue from cancer work than other elements of their jobs.

Ability to concentrate and listen to cancer patients and see them as individuals increased at the posttest. Those reporting that they could always or often listen to their cancer patients increased so that by the posttest all ten fell in those two categories. Similarly, reports indicated a decline in difficulty viewing cancer patients as individuals with unique problems.

These findings in relation to attitudes, behaviors and feelings indicated that some changes occurred in each area. Primarily, they suggested that workers

became more aware of the complexity of their work with cancer patients and its stresses. They also seemed to find the work more satisfying and became better able to concentrate and listen to patients, seeing them as unique individuals. The group and other forms of peer support seemed to substitute for some former uses of supervision and for some degree of interest in seeking programs related to cancer.

Feelings of competence in the job were strengthened and identification with clients decreased in intensity, but both apprehension about seeing cancer patients and depression when patients die were found to increase slightly. Since the nature of the participants' work remained stable and since they reported increases in coping ability and in interest in cancer, increases in apprehension and depression suggest that the program may have sensitized the participants and increased their awareness of such feelings.

The Most Problematic Issue

The evaluation sought to identify changes in participants' perceptions of what was most difficult about their jobs, as perceived before and after the program. An instrument developed to record the most problematic issue identified by each participant was administered at the first session of the program, before any discussion had taken place. (See Appendix 5.) Sub-

sequently, each participant was interviewed outside the group to permit elaboration of unclear issues and expansion of themes and concerns reported. When the questionnaire was readministered after the program terminated, initial responses were returned so that each participant could assess any change in perception of the most problematic issue. The follow-up questionnaire included a brief summary of content of the individual interview which had followed the first response. Participants were also presented with a comprehensive list of the issues identified as most problematic by other group members and were asked to rank them in order of importance.

Initially, issues most typically presented as of primary concern focused on the workers' sense of the gravity of the diagnosis of cancer and their lack of hope about the cancer patients' prognosis. Two workers specifically characterized their concerns as "hopelessness experienced in this work" and "feeling hopeless about the medical prognosis." The primary concerns of two others were "society seeing cancer as a death sentence" and "the societal generalization that cancer means death." On a similar issue, another worker had the greatest difficulty with the uncertainty of the patient's medical course, literally changing from day to day.

Other primary concerns also related to the severity of the illness and its implications for the worker.

One worker specified the lack of opportunity to talk with other professionals about feelings related to the work. Two workers considered that their greatest problems resulted from the lack of direct discussion between doctors and patients about the specific nature of the illness. One of them related the absence of such discussion more to protectiveness of families and the other saw it as the outcome of lack of coordination between professionals involved in the patient's care. There was a reference to cancer being "brushed under the rug" throughout the hospital system.

Two responses indicated concerns less directly related to the seriousness of the cancer diagnosis and its negative or uncertain prognosis. One was concerned about impersonal treatment of patients in the hospital. The other focused on the lack of resources available in the community to families in need of a wide range of services.

These findings are congruent with the analysis of content themes of the group discussions. Dominant themes within the group related to the uncertainty of prognosis, and sense of hopelessness of the workers, often despite optimistic medical opinions.

When participants were interviewed, they had the opportunity to expand on their responses and to introduce other areas of concern. For the most part, workers elaborated their initial concerns, providing more de-

tailed examples and explanations. In this way, interviews served to confirm the importance of issues such as their pessimism about cancer, difficulty in working with patients who might not know their diagnosis, and isolation of the social worker from other professionals. Such isolation seemed to be related to their differences of function and role as well as beliefs. Workers did not want to be a part of a system which avoided giving patients information about their illness, and found it difficult to work with over-optimistic patients or with patients whose anger became focused on the social worker when he/she introduced unpleasant realities, such as the need to plan care after discharge from the hospital. Interviews revealed additional data, particularly in relation to coping efforts. Participants described the following ways of coping with problems in their work:

Separating work from home life

Gaining support from teamwork with other professionals

Obtaining satisfaction from patients' acknowledgement of the value of service

Accepting death as normal (from a distinct cultural perspective)

Retaining hope of seeing a cure for cancer developed. While each of these supports to coping efforts was discussed within the group sessions, they were related to the investigator in interviews with more detail and were presented as of great value to the cen-

tral coping pattern of the worker. For example, one staff member reported that she relied substantially on religious and philosophical beliefs which placed death in a continuum of life stages rather than as final. This social worker felt strengthened by such beliefs in work with many patients with fatal illness. Another member who emphasized the recognition by patients and families of the value of professional assistance from the social worker showed the investigator a file of letters and cards from appreciative clients. Another saw the group's value in helping to diminish a sense of frustration, "...partially with other suggestions; primarily in helping me see that what I can do and have done to assist people has been a tremendous help to those people."

Overall, it seemed that members had been able to use the group positively in modifying their coping with highly problematic aspects of their work. Yet such benefits were also accompanied by the persistence of the issues named as primary concerns. This was not unexpected, since the issues reported as problematic were enduring problems such as societal views of cancer as equated to death¹³ or major problems typical of those widely reported by social workers in medical settings.¹⁴ Difficulties such as the lack of appropriate medical information provided to patients and the lack of integration of medical and social planning have been widely reported.¹⁵ As Nacman states,

Social workers who press for more humane, dignified treatment and the protection of patients' rights are sometimes labeled overprotective and unrealistic. Their concern for environmental and organizational change may be viewed as irrelevant and even disruptive.¹⁶

When members were asked to reconsider the issue most problematic to them, eight reported some changes as a result of participation in the program. Of those who noted modifications, some attributed such changes to recognition of the commonality of the problem within the group, and support which was derived from such mutual recognition. One worker stated, "I realized each worker was trying to cope with uncertainty and feelings of being out of control as far as the patient's diagnosis and prognosis were concerned. From my experience in the support group I have found that it is possible to receive and give support within the department...."

Others stated that self-awareness had been increased by the group process and enabled them to modify attitudes. One stated: "Being able to share the above with others has made me realize that I should be more assertive in seeing that doctors inform patients and families about disposition. In general, it helped to discuss these problems because I learned that other social workers have the same problems. I became more aware of my feelings about dealing with cancer patients."

Some workers specified that the modifications in their perceptions of problems resulted from suggestions

offered within the group. One stated that the group helped "...to individualize the work problems more specifically and see some alternative ways to cope." Exploration of the most problematic issues generated additional data in relation to the group process, supplementing evaluation of that aspect of the program. One worker noted that concerns about confidentiality, mistrust and doubts about the ability of an unknown leader to help had all been dispelled in the course of the program with the result that the group experience had been both educational and supportive.

Effects on Work Behavior

An additional measure of program outcome was the translation of program effects into the daily work activities of the participants. Evidence of such application was drawn both from participants' self-reports during the project and their responses to the evaluation questionnaire.

1. Importance of Support in
the Development of
Coping Skills

During group discussions, as members identified problems on the job, they described efforts to cope with those problems and sought the assistance of their peers. On occasion, they also reported that their method of dealing with a job problem had been directly influenced by experience in the group. One example was provided by

a worker who had helped a patient transfer to a terminal care facility at which the patient died shortly after admission. A doctor involved in the case blamed the social worker for facilitating the transfer -- an ironic situation for social workers who are pressed by hospitals to arrange such transfers. The worker reported to the group that, as a consequence of recognizing from the group experience that support would be valuable, the help of a coworker was sought as a listener and support for the worker. In another example, a supervisor noted that the group experience influenced her relationship with a supervisee, also a group member, encouraging her to share experiences which previously she would have kept to herself.

Some responses to the participant evaluation questionnaire were not specific in describing the effect of the program on work behavior but focused on the importance of knowing that other members experienced similar problems. This sense of support was valued as an important component of increased coping ability although its specific impact on daily work was not described.¹⁷

2. Realistic Self-Expectations

Participants specified ways in which they felt better able to cope with job stress related to cancer and included the development of more realistic expectations of what could be accomplished. One worker re-

ported "more realistic expectations of what is 'good' work and greater awareness of how much my intervention has helped."

3. Assertive Behavior

Another group of responses specified an increase in assertive behavior, with better ability to communicate with other health professionals. One worker reported being "stronger and more self-assertive in dealing with staff about cancer patients."

Program Effectiveness: Participant Ratings

The effectiveness of the program as rated by participants was assessed by means of an evaluation instrument developed for the project and administered two months after the program concluded. Analysis of the questionnaire results yielded the following data: As Table 12 illustrates, some objectives were more successfully achieved than others. The investigator's initial expectation that the development of support would entail training and that, consequently, knowledge and skills would be increased was not fulfilled. This became evident in the agenda developed by and for the group. Those members interested in skills training were in the minority and did not press their interests. As a result, the majority interest of focusing the group on mutual aid and cohesiveness dominated. The group's discussion of

TABLE 12
PARTICIPANTS' EVALUATION OF THE
PEER SUPPORT PROGRAM

Program Objectives	Extent Achieved				
	Not At All	Hardly	Some- what	Quite a Bit	Very Much
Increase knowledge and skills in rela- tion to work with cancer patients	1	1	6	2	0
Increase knowledge and skills in rela- tion to stress ex- perience in such work	0	1	4	3	2
Have participants identify stresses and problems in their work	0	0	0	6	4
Have participants offer solutions to the stresses and problems identified	0	0	4	4	2
Have participants assist in planning the program of support	0	2	2	5	1
Have participants assist in planning for continuing peer group support beyond the program	0	0	2	6	2
Increase preparation for coping with job stress related to cancer (compared to before the program)	0	0	6	4	0

the place of training, development of practice skills and acquisition of knowledge for practice was reviewed in Chapter III (pp. 130-131)

In contrast, however, most members rated the program as increasing knowledge and skills for coping with stress experienced in their work. This finding is congruent with the investigator's analysis of the group process. Although specific information about cancer and its impact on patients had not been introduced in the program, there had been a major emphasis on workers' responses to stress and coping devices. As a result of the leader's contributions and the group's mutual aid process, workers had been able to expand their knowledge and skills as they exchanged ideas in relation to ways of coping.

It was noted that one member stated that attention to training would have to follow the development of a group within which there could be sufficient trust to permit identification of problem areas.

This assessment is supported by Wattenberg in work with family day care providers.¹⁸ Wattenberg also cites the work of Sherburne who observed that "peer group experience without an explicit training focus can stimulate interest in training for the future."¹⁹

Participants said even more definitively that the program was successful in helping them identify stresses and other problems in their work. This finding

supports the analysis of group process which identified the delineation of stresses and problems as a major theme of the program. It also confirms the investigator's assessment that members themselves took active responsibility for identifying the stressful components of their jobs.

The objective of having participants offer solutions to the stresses identified was also evaluated by members as well achieved. All reported some positive achievement, with six in the categories of "quite a bit" or "very much." This also provides confirmation of the analysis from group process that members took an active role in offering solutions within a developing process of mutual aid.

The objective of having participants assist in planning the program was assessed as less successfully achieved. Although six members thought that the program had involved them in planning, two stated that this was only "somewhat" the case and another two thought that it was "hardly" so. This was at one level a surprising finding, since the members played a major role in determining the group program's content week by week. It suggested that other aspects of planning, such as the presentation of a relatively structured program, with size of group, time, place, frequency, number of meetings and leader prearranged, were also important. Although members came voluntarily and could affect the discussion

content, and to some extent the duration of the program, most plans were in place and not amenable to their influence.

In contrast, all members thought that the program had been at least "somewhat" successful in having them assist in planning for continuing peer support beyond the program. Eight members reported that it had been "quite a bit" or "very much" successful in regard to that goal.

Members were asked to evaluate how well-prepared they felt to cope with job stress related to cancer, compared to before the program. Responses suggested that the program was successful in its goal of enhancing such coping. All workers reported greater preparation, with six "somewhat" better prepared and four "quite a bit" more prepared. There were several reasons cited for feeling better able to cope. Participants reported feeling stronger and more self-assertive in relation to their work. One reported greater ability to express anger about cancer and job stresses. Another was more self-assertive in dealing with staff about cancer patients. One participant reported having more realistic expectations of what constituted "good" work and, similarly, another reported decreased expectations of being able to cope with "every case situation, all of the time." Recognition of the commonality of workers' stresses and the sense of unity with other group members

were reported by participants as aids to coping which resulted from the program.

Participants were also asked about factors contributing to increased ability to cope. The most frequently cited response (five workers) was that the knowledge that feelings and problems related to the work were shared by other members was helpful. The support of other members was noted by three workers. Other factors noted included having an outlet for feelings of frustration, development of greater self-awareness in relation to the work and becoming less compulsive about the work.

In response to the question of how necessary a support and training program was for preparing staff to cope with the stress of work with cancer patients, all participants agreed upon its necessity. One thought it "somewhat" necessary; three "quite a bit" and six "very much" needed.

All participants commented on aspects of the program that they liked best, with most responses focused on the value of sharing and support. Five workers referred to "sharing," "support," or "acceptance" of their ideas and feelings. Others noted the openness of the group, the sense of teamwork and the ability to discuss concerns and fears related to the work. Thus, one member valued, "the sharing of feelings and having others listen and care about how I am coping."

Aspects of the program that were least liked were identified by all but one member (whose evaluation indicated a high level of satisfaction). The most commonly mentioned aspect was the intrusion of the program into working hours and the resultant pressures to complete assignments. One participant liked least the fact that the program did not continue for longer. Three participants would have preferred more specific focus on a cancer related topic for each session and two would have liked more focus on knowledge and training.

These findings support the investigator's judgment that the project's emphasis on peer development of program content resulted in a diminished focus on knowledge and the exclusion of training.

All group members identified the program's value in bringing workers together for mutual support. It was described as "helpful" and of "enormous value." One member noted that the program was "a forum for learning how others cope and how to expand one's own skills...." Another commented that it "helps self-awareness of feelings and attitudes, for the goal of better self-control and teamwork."

Participants made recommendations with regard to planning future programs. Several recommendations were related to the conflict experienced between valuing time in the group and feeling the pressure of work demands. Seven members suggested that each session be of one

hour's duration, while three preferred the one and a half hours of the program, or longer. Six felt that the number of sessions held was appropriate; one would have preferred six sessions. Three thought that the program should become an ongoing part of staff development programs. There were differences in number of members considered desirable, with some increasing and others decreasing group size. All changes were within the range of six to twelve members. Two participants specified a preference for an interdisciplinary membership.

Nine participants recommended that the program have a leader and one did not comment. Two emphasized that the leader should be drawn from outside the department but considered the possibility that, if the group became a permanent feature of the department, internal leadership might be developed. Two proposed rotation of the leadership, with each group member taking responsibility for a few sessions of an ongoing program.

In relation to program content, responses were equally divided between those which recommended continuation of the open agenda used in the group (with its focus on sharing and discussion of feelings, and its emphasis on support) and those which recommended more educational content. Suggestions for additional content included reading materials, audiovisual aids and case presentations. It was proposed that initial sessions should take an educational focus which would then lead to the group's

development as a discussion and support group.

As noted earlier, discussion of the educational component at the final session of the program included the view that the group could have obtained the maximum benefit from training opportunities only after developing cohesion as a group. There is broad support for the addition of some didactic content, but no clear guidelines for the appropriate stage at which to include such material. In the sample group, the need for development of a climate conducive to peer support was so apparent that it suggested to the leader that an appropriate time for inclusion of training would have been in the "work" phase, when the group had formed, established its norms and priorities for training.²⁰

Unanticipated Program Consequences

Weiss points out that in program evaluations unplanned effects may be observed both by informal and by structured measures.²¹ In this project, several sources of data were used. All findings, including the group process as monitored in logs and tape-recordings, questionnaire responses and information received from sources other than members were searched for unanticipated consequences. Efforts were made to "take into account interrelationships between program efforts and the overall system in which people function."²² Unplanned effects were analyzed in terms of their impact on

the members, the social work department as a whole, and the group leader.

Consequences for Group Members

The group's decision, at the end of the program, to continue as a support group was unanticipated. The study's hypothesis was that participants would find the group program helpful for development of better coping skills. Although it was assumed that gains made during the program would be maintained in ongoing work with clients, the group was not expected to continue on a long-term basis. The participants' decision to continue as a cancer support program was, therefore, an unanticipated outcome which had unforeseen ramifications.

Although it had been recognized that the project was undertaken in a department in which few groups existed, it was not anticipated that the short-term group program would have effects on areas of the job unrelated to cancer. It became evident, however, that the development of support and mutual aid in relation to their cancer work made workers conscious of more widespread needs for peer support. Workers reported that they experienced a lack of support in other areas of their jobs. While cancer work was clearly experienced as particularly difficult and emotionally draining, other areas of the workers' mixed assignments were also identified as stressful. For example, a worker assigned

to pediatrics spoke of the emotional stress of working with abused children and their parents. Thus, the project had the effect of heightening group members' consciousness of job stresses and the consequent needs for support in relation to many aspects of their job.

In bringing together workers whose assignments were diverse, with inclusion of cancer patients the only common link, the project initiated a process of discovery of common concerns and issues among workers who had never recognized the commonality of their professional dilemmas and struggles. As a consequence, the group members identified an unmet need for greater communication between members of the department. They perceived such communication as a vehicle for providing new levels of information and support which could enhance work skills and satisfactions. One worker stated that opportunities to talk to peers decreased isolation and that they were "helpful and even inspiring." Other workers then spoke of feeling "high" when colleagues worked collaboratively and talked together about difficult work. They noted with regret that such communication was rare.

The mix of line workers and supervisors in the group had been expected to present some difficulties for the development of peer support and mutual aid. Minimal negative effects were observed, as noted in the preceding analysis (Chapter III, pp. 107-108). Indeed, it would

seem that the presence of supervisors may have had important positive effects. As already indicated, the supervisors and their supervisees began to develop new forms of supportive relationships, focused on their common concerns as practitioners and based on a high level of mutuality. This may be important in consolidating the coping gains which workers accomplished. As Weiss says of programs "that teach new styles of work, the responses of supervisors back on the job may be crucial for the retention or fade-out of the lessons taught."²³

By the time of the follow-up research, one member reported that she had changed her assignment to an area with reduced exposure to cancer patients. While her decision to leave an assignment heavily focused on cancer cannot be directly attributed to the group program (this was the member who attended only four sessions) its impact must be considered. The active participation of this worker during the sessions attended indicated a great interest in the group content and revealed many strong concerns about the stressful nature of the work. This was the member who asked on one occasion, "What am I doing being a cancer worker?" It is, therefore, considered that one effect of the program was that exposure to concentrated discussion of the stress of cancer may have helped the worker to recognize more fully difficulties experienced in maintaining the

assignment, and thereby promoting a decision to change assignments when such an opportunity arose. This was an unanticipated consequence of the program which might be construed as a positive outcome in that the worker chose to act upon increased sensitivity to the stress of the job, choosing to work in an area where she could provide services to clients with less discomfort. It is presumed that better services are provided when a worker feels less stress, as contrasted to the reduced effectiveness noted in literature on burnout.²⁴

Consequences for the Social Work Department

Although a primary goal had been the development of peer support related to work with cancer patients, it had not been anticipated that the group would continue after the program terminated. Some effects of the continuation must be considered. It became evident that the department had to accommodate to an ongoing group whose members felt that they had established a special relationship. Participants discussed their expectation that other staff, including non-MSW workers who had been excluded from the project, might object to the program's continuation as an exclusive group.

At the time of the investigator's follow-up visit, those group members who continued to meet were considering the need to have a leader rather than be an exclusively peer support group. Their request that the

department provide an experienced group leader presented a demand for resources which had not been anticipated.

Consequences for the Leader

Despite familiarity with the setting, the investigator had not anticipated the full impact of the departmental culture on group process and consequent leadership requirements. The eager response of the members to the supportive environment of the group led the investigator, as the group leader, to allow a too rapid initial pace in the group process. (See Chapter III, p. 156.) The work which was then necessary to stabilize the group and develop a climate conducive to discussion of important themes may have precluded or limited some potential program content, such as provision of information about specific aspects of cancer and its implications for practice. Thus, the leader's expectation that in addition to establishing support and mutual aid, the group would become engaged in an educational component was not met. Because of the influence of the setting on the participants, the development of trust was a lengthy process which called for a high level of leadership skill. (See Chapter III, p. 151.) It became clear that in order to develop and incorporate a specific training component related to cancer into such a support group, a program of longer duration would be necessary.

In summary, the evaluation of this program has illustrated strengths and weaknesses of the project as implemented. Participants benefitted in numerous ways and reported considerable satisfaction with the program as undertaken. Valuable suggestions for modification emerged, although most participants found relatively little that they disliked in the program. While the project's objectives were not fully attained, primary objectives such as the generation of new data related to stress and coping in cancer work and the development of peer support and mutual aid were substantially achieved.

CHAPTER IV - FOOTNOTES

¹Novia Carter and Brian Wharf, Evaluating Social Development Programs (Canada: Canadian Council on Social Development, 1973), p. 81.

²Tony Tripodi, Phillip Fellin and Irwin Epstein, Differential Social Program Evaluation (Itasca, Ill.: F.E. Peacock, 1978), p. 84.

³Carol H. Weiss, Evaluation Research (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1972), p. 75.

⁴Ibid., p. 33.

⁵Tripodi, Fellin and Epstein, op. cit., p. 50.

⁶Edward A. Suchman, Evaluative Research (New York: Russell Sage Foundation, 1967), p. 61.

⁷For the importance of the social accounting function in program evaluation, see Tripodi, Fellin and Epstein, op. cit., pp. 59-62.

⁸For analysis of levels of participation, see pp. 141-150, above.

⁹Ayala Pines and Christina Maslach, "Characteristics of Staff Burnout in Mental Health Settings," Hospital and Community Psychiatry 29:4 (April 1978), p. 233.

¹⁰For a discussion of differences in support from the group and from supervision, see pp. 128-130, above.

¹¹Weiss, op. cit., p. 38.

¹²Richard G. Weigel and John G. Corazzini, "Small Group Research: Suggestions for Solving Common Methodological and Design Problems," Small Group Behavior 9:2 (May 1978), p. 211.

¹³Susan Sontag, Illness as Metaphor (New York: Farrar, Straus and Giroux, 1977).

¹⁴See, for example, Harriett Bartlett, Social Work Practice in the Health Field (New York: NASW, 1961); Emanuel Hallowitz, "Innovations in Hospital Social Work," Social Work 17:4 (July 1972, pp. 89-97; and Stacey Lee, "Interdisciplinary Teaming in Primary Care: A Process of Evolution and Resolution," Social Work in Health Care 5:3 (Spring 1980), pp. 237-244.

¹⁵Martin Nacman, "A Systems Approach to the Provision of Social Work Services in Health Settings: Part 2," Social Work in Health Care 1:2 (Winter 1975-76), pp. 133-143.

¹⁶*Ibid.*, p. 136.

¹⁷Cary L. Cooper, "Social Support at Work and Stress Management," Small Group Behavior 12:3 (August 1981), pp. 285-297.

¹⁸Esther Wattenberg, "Characteristics of Family Day Care Providers: Implications for Training," Child Welfare 56:4 (1977), pp. 211-229.

¹⁹*Ibid.*, p. 219.

²⁰*Ibid.*

²¹Weiss, *op. cit.*, p. 34.

²²*Ibid.*, p. 33.

²³*Ibid.*, p. 108.

²⁴Pines and Maslach, *op. cit.*, p. 234.

CHAPTER V

SUMMARY, IMPLICATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

Summary

This study was undertaken to determine whether a program of support would help social workers in general hospitals cope better with stresses which they experience in working with cancer patients. The necessity for the study came from concern that, because of an increasing population of cancer patients, many social workers are becoming involved with cancer patients and their families and that the workers lack adequate supports to help them cope with the stresses experienced. In the face of the painful emotions associated with cancer and its life-threatening implications and drastic treatment requirements, social workers, like other hospital staff, often turn to coping strategies which reduce their direct involvement with clients.

The study sought to assess the need for special programs to help social workers cope with the stresses of their work with cancer patients and to design and implement an innovative program, in one hospital, to meet the needs determined. The target population in

both phases of the project consisted of social workers who are involved with cancer patients as one part of their work in general hospitals. The model selected for the program, using peer group mutual support, is timely both because of recommendations for support emerging from numerous studies of worker burnout and because of increasing professional recognition of the value of mutual aid as a helping system.

A study of research relevant to the study's purpose focused on the nature of stresses experienced by social workers in the cancer field, the nature of worker burnout, an apparently related phenomenon, and the nature and components of the notions of coping and support. Support for the assumption that the emotional impact of cancer causes stresses for social workers who work with cancer patients was found in literature which documented the universally stressful effects of the illness. It also became evident that the study would break new ground in its documentation of difficulties reported by social workers in a general hospital since there was a lack of systematic study of the specific problems of such workers.

The project's secondary goal of developing a model program to support participants and enhance their repertoire of coping methods became more clearly defined as existing research was reviewed. Such programs were recommended in studies of both burnout and coping as

possible aids to increase the quality of client service. Previous research on support and coping suggested that any changes in coping behavior would be most likely to occur within an atmosphere of support.

Methodology

Plans for the program emphasized the mutual aid process between peers, and exchange of information as a source of increasing knowledge and coping skills. Since little conclusive material was available in relation to the role of a leader in an essentially peer support group, this facet of the program was identified as an important aspect of the study.

In order to determine the level and degree of stress experienced by social workers in their work with cancer patients and their means of coping with such stress, a needs assessment survey was conducted. Survey respondents were 36 MSW social workers drawn from varied assignments at five New York area hospitals. Although the small, non-random sample limited the extent to which the findings could be generalized, support was found for the proposition that social workers serving cancer patients experience both stresses and satisfactions and that a structured program of support would enable workers to cope more effectively with the stresses.

Implementation

The site chosen for implementation of the model program was a large, voluntary teaching hospital with a well-organized social work department. The sample group was restricted to workers with Master's degrees and was composed of ten self-selected workers, including two whose work combined direct practice and staff supervision and four who were their supervisees.

The program, which was implemented in the fall of 1981, was extended at the request of participants from eight to nine sessions of one and a half hours. The content and focus incorporated suggestions derived from the needs survey and was open to modification according to participants' needs and preferences. When the program ended, the participants continued to meet every other week as a leaderless peer support group.

Evaluation

Group process and development were monitored by the maintenance of attendance records, logs and tape-recordings. Since this was an exploratory study, intended to provide information about a worker problem and a model to resolve it, the primary emphasis of the evaluation was ongoing and formative. Evaluation of the program's success in developing support and mutual aid was based on analysis of group content themes and on participants' program evaluations. Secondly, the evaluation

assessed the outcome of the program in terms of its effects on participants. It was hypothesized that the support program would have a positive impact on the ability of participants to cope with job stresses related to cancer. This impact was evaluated by assessing changes in workers' self-reported attitudes, feelings and behaviors in relation to their work with cancer patients, by examining changes in their perceptions of their most serious problems and by identifying effects on work behavior.

Themes of the Group

Many themes that emerged in the course of the program were related to sources of stress and workers' coping patterns. Workers stated that they found the special needs of cancer patients and their families demanding and that they found the pain, disfigurement and frequency of deaths associated with cancer distressing. There was variation in the degree to which the workers became close to clients and consequent variation in the impact of loss when patients died.

Job stresses were also connected to the more general role of social workers in the hospital and to the lack of support for staff. Sources of satisfaction such as teamwork and a sense of value of the work were also noted.

Coping patterns included detachment and separation of work from home life, religious beliefs, withdrawal into other work, and support from peers and supervisors.

Other themes which were related to the nature and progress of the program included training, group tasks, the value of the group and the need for a continuing program.

Group Process

The development of the group was traced through four phases. In the initial phase, members had to overcome the anxiety associated with exposing their practice and personal reactions in a group which included supervisors, little known coworkers and an outside leader. The next, and more intimate, phase was characterized by a high level of spontaneous participation and eagerness to share broader experiences than the work with cancer patients alone. The third phase included more caution and the reestablishment of the commitment to focus on reactions to cancer and the development of peer support. This phase, in which the level of interaction was high and in which support and mutual aid became well developed, continued until the last scheduled session. The fourth, or termination phase, was begun in the eighth session but required an additional meeting to complete the assessment and termination process.

Although some spoke infrequently, all members participated in the work of the group. Initially, supervisors were prominent in taking leadership and aiding the group in overcoming obstacles to its work but other workers became active as initiators of change in the later phases.

Analysis suggests that the activities and functions of the leader were important for the development of a climate suitable for the establishment of peer support and mutual aid. Independence from the leader and ability to function as a group of peers became evident and as members developed a sense of having accomplished work together, they made the decision to continue as a leaderless group.

The process of developing mutual aid, the expressed purpose of the group, involved the discovery of unity of interests, the exposure of common concerns and experiences and the growth of trust. Support and mutual aid were offered in various ways and increased in frequency with evidence that participants found the help of the group extending to their practice.

Outcome

Evaluation of the project, based on analysis of the group process, measurement of change in participants' attitudes, behaviors and feelings in relation to cancer and participants' ratings of program effective-

ness, indicated that the goal of developing a model program for peer support and mutual aid was substantially achieved. Other findings were that participants became more aware of the complexity of their work with cancer patients and its stresses. They found work more satisfying and became better able to concentrate and listen to cancer patients, seeing them as unique individuals. Feelings of competence were strengthened and over-identification with clients decreased in intensity after the program. Some increases in apprehensiveness about seeing cancer patients and depression when patients die may indicate that the program increased workers' sensitivity and awareness of such feelings.

Participants found the group helpful, placed value on "sharing," "support" and "acceptance," and found little that they disliked in the program. There was broad support for the inclusion of didactic content in the program, but no clear guidelines emerged for the stage at which it should be included.

Effects of the program which had not been anticipated included the decision to continue on a long-term basis and the heightening of consciousness of stresses and consequent needs for support in all areas of the job.

Limitations of the Study

Both the needs assessment survey and the model program were conducted with small, purposive samples. As

a result, generalizations beyond the sample group must be made cautiously, and implications drawn from the study need to be viewed as tentative.

Since it was not possible, for practical reasons, to implement the program at more than one site, there is no way of ascertaining which aspects of the program's development and its effects have universal significance and which are unique to the particular group and setting. The absence of a control group leads to a lack of assurance that observed effects were due to the program rather than to another explanation. Thus, the project is, in Weiss's terms, "the prisoner of its setting."¹ For greater generalizability of the results and their interpretation, the study would need to be validated with a larger and more comprehensive sample.

Because of time constraints for the project, effects of the program were evaluated only once, two months after termination of the group sessions. Ideally, this evaluation would be repeated to see whether effects attributed to the program persist over time.

The study did not investigate differences among participants' responses to the program and did not explore which workers might best use the program. Since it had not been anticipated that the sample group would include great diversity of experience or status, measures were not developed to determine differences in effects and benefits between line workers and super-

visors or between experienced and inexperienced workers.

Implications for Practice
and Future Research

Since some stresses related to work with cancer patients were relieved by the program, this study suggests that hospital social work departments should consider the development of programs for staff support in relation to cancer. Participants in this project recommended that peer groups should be the basis for such support. While this had been the model for the project, it had not been anticipated that the study would produce data related to differences between peer-based support and that derived from supervision. Although it did not become a major obstacle to the development of mutual aid, it was recognized that the presence of both supervisors and supervisees in the sample group might inhibit peer support. As a result of the mixed levels, the contributions of supervisors and peers to workers' overall coping and support were explored and the findings may have important implications for social work practice.

While supervision was valued for administrative direction and for teaching, it was not perceived as a major source of support. Despite supervisory efforts to be supportive, the lack of reciprocity in supervisory relationships was seen as limiting the extent to which trust and sharing could develop. Since the supervisory

structure is such that workers are never in the role of helper to the supervisor, the worker fails to obtain the benefits of the "helper therapy principle"² so critical to mutual aid.

A unique component of the support offered by peers (and within the project this included the supervisors, since they came to the group as workers with their own caseloads of cancer patients) was the personal disclosure and sharing which occurred. This narrowed the distance between all members, including supervisors, and permitted the growth of mutual aid.

This finding suggests that even in departments with adequate and highly competent supervision, the value of peer groups for staff support should be considered and tested.

Consequences of the support program that should be taken into account in related research and planning include the possibility that the presence of a special group may have effects on the department as a whole. As Weiss states, "Sometimes programs tackle one aspect of a complex problem. Even if they achieve good results in their area, the more important effect may be to throw the original system out of kilter."³ Although no serious consequences of the program were noted, there was evidence to suggest that other members of the staff might feel excluded from the group and that there could be a negative impact on staff morale. There was also the need

to consider the group as potentially long-term, requiring permanent allocation of resources such as leadership. Certainly, the effects on both departmental resources and morale must be considered in developing programs which offer special help or privileges to groups of staff.

Another aspect of the program with broad organizational implications was the sensitization of staff to job stresses other than those related to cancer. As group members focused attention on the stresses which they experienced and the coping patterns which they used, they identified other areas of their work which were stressful, and highlighted needs for support in relation to other aspects of the job.

Therefore, in planning a support program focused on a specific area of practice, it is important to anticipate separate but related issues that might be affected by the program and other needs which might be revealed.

During the planning phase of the project, it had been anticipated that the most likely participants would be young and inexperienced workers. The unexpectedly diverse composition of the sample suggests questions to be pursued in further research on support programs. Participants who are motivated to increase their coping ability would be desirable but it is not known to what extent interest in support programs derives from personal or job-related reasons (such as supervisory pressure).

Nor is it known whether a particular group of workers would benefit more than others. In future research, more definitive information about reasons for participation would be helpful for understanding which workers might benefit most from support programs. Although the mixed levels of experience in the sample group may have been a source of strength for the project's development of mutual aid, future research might focus on differences in support groups which have participants of more homogeneous experience levels.

In the project's exploration of coping patterns, it was found that the coping described fell within the parameters suggested by the needs assessment and other research. During the course of the program, and especially during interviews with participants, it became evident that members' background characteristics and general coping style also influenced their ways of coping. While each relied on a variety of means of coping, based on a common pool of such aids, emphasis was placed on different aspects and sources of sustainment such as religious philosophy, family support, sports and entertainment. The data suggest that research should include consideration of the influence of background characteristics such as ethnicity, religion and marital status as well as factors included in this study, such as age and years of experience, in contributing to coping patterns.

Changes to be Considered for Future Implementation

In considering elements of the program that would be changed, all aspects of the evaluation were used. This follows Weiss's assumption that, "Although results from a single case study are not readily generalizable to other programs, they can provide insights that will help the program improve its operations."⁴

Planning

Prior to implementation, the format of the program should be planned jointly by the leader and group members. Permitting members to contribute directly to decisions about scheduling, frequency and times of meetings might facilitate improved attendance. Topics of interest for the didactic component of the program could be identified. This would allow the leader an opportunity to gather appropriate resources such as literature, in preparation for later sessions. Serious consideration should be given to a program of ten or twelve rather than eight sessions, as originally planned (nine as implemented), in order to allow adequate time for the group to move through all necessary phases of development and have adequate opportunities to incorporate educational content.

Implementation

As noted in Chapter III, evaluation of the group process suggested that a slower pace in the initial phase of the program might bring the group to a point of cohesiveness more smoothly and even more rapidly. In a future program the leader should actively promote a slower pace in the first few meetings by maintaining the agreed focus of the program and by holding participants to the development of a contract for the work of the group. The members' eagerness in the model program to discuss general work stresses led to an outpouring of discontent. Since this occurred prior to the establishment of trust, some hesitation ensued which delayed the group's entry to a task focused phase. Given the similarities of a group in the workplace to a natural group, where enduring relationships exist, the issue of confidentiality should be taken up by the leader very early in the program and built in to the group's contract for work.

In future groups, the investigator would be more attentive to the cognitive elements of support by introducing a specific training component. This important area, relegated to a minor role because of the participants' eager response to the group's central purpose of developing mutual aid, would be given greater consideration, although remaining secondary to the development of

peer support. As suggested by some participants, a future program would move to didactic content after the group established a high level of cohesion. With a more structured approach in the "work" phase of the group, members would be asked to specify topics of interest for training. The leader would provide resources and information and call upon members of the group to share specific areas of expert knowledge. The introduction of teaching content might require the use of audiovisual aids.

More attention would be paid to the possibility of the group continuing as part of the department's staff support program. Various patterns of leadership might be discussed and tested as part of the program.

Evaluation

While many aspects of the evaluation component of the project were satisfactory, producing new data and directions for future research, the following gaps should be remedied. More data are necessary to permit evaluation of the transfer of program effects into daily activities. Measures should be sought or developed to elicit important data related to new ways of coping with job stresses. Data which would have enhanced the evaluation were those related to the central program goals of establishing peer support and mutual aid. Additional questions asking specifically about experiences of mutual

aid would be desirable. Derivation of such data from questionnaires would have strengthened evaluation of this aspect which was based primarily on the investigator's analysis of tape-recorded discussions. (For fuller consideration of changes necessary in data collection instruments, see Appendix 9.) Instruments to measure changes in attitudes, behaviors and feelings related to stresses and coping in work with cancer patients should be more sensitive to change with a small population, since the nature of the program model requires restriction of group size.

Conclusion

Overall, the value of this project is in its delineation of the significant stresses experienced by social workers who work with cancer patients in general hospitals; its specification of coping patterns used by such workers; its development of peer support and mutual aid through a group program and its finding that the group program helped the workers to modify their ways of coping with highly problematic aspects of their work.

CHAPTER V - FOOTNOTES

¹Carol H. Weiss, Evaluation Research (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1972), p. 79.

²Frank Riessman, "The 'Helper Therapy' Principle," Social Work 10:2 (April 1965), pp. 14-25.

³Weiss, op. cit., p. 33.

⁴Ibid., p. 75.

APPENDIX 1

Study of Social Work with Cancer Patients in General Hospitals

Your response to this questionnaire contributes to the survey phase of a study related to social work with cancer patients. The study will explore types of support and training which help social workers in general hospitals whose assignments include cancer patients.

Names of respondents are requested for possible telephone follow-up on unclear data but will not be identified to anyone other than the researcher.

The questionnaire should take no longer than 25 minutes.

Post MSW

Pre MSW

1. How many years have you been a social worker?
2. How many years have you worked in a hospital?
3. How many years have you worked with cancer patients?
4. About how many cancer patients do you work with monthly?
5. What proportion of your total workload does that represent?
6. How do you generally get your patients?

referral	_____ %
self-referral	_____ %
active case-finding	_____ %
other (specify)	_____ %
total	100%
7. Do you see all cancer patients on your service (clinic, floor,)?
 - a) If yes, why? (department policy, worker decision, etc.)
Please explain.
 - b) If no, how do you select those to be seen? Please explain criteria, etc.
8. Would you say that cancer patients experience different problems from other patients you work with?

If yes, what are some of those differences?

9. Does work with cancer patients offer special satisfactions?
If yes, of what kind?
10. Is work with cancer patients specially stressful?
If yes, in what ways?
11. What helps you cope with job stresses? a) on the job?
- b) after work?
12. Would you prefer a different patient population?
Please give reasons for your answer.
13. Would you accept an assignment where all the patients had cancer?
Please give reasons for your answer.
14. About what proportion of your cancer patient caseload dies
during the time you work with them?
15. What do you usually do when a patient known to you dies?
- a) in relation to the patient's family?
- b) in relation to your own feelings?
- Now I would like to ask about any training you may have had.
16. Do you have any special training related to cancer?
If yes, of what kind? (where, when, why obtained, etc.)
17. Would you want (further) training?
18. If yes, of what kind? or If no, can you say why not?

19. When do you feel the greatest need for support in your work with cancer patients? In relation to:

- a) particular client characteristics? (please specify)
- b) stage of disease (specify)?
- c) other (specify)?

20. From what sources are you most likely to get the support you need?

21. How often do you discuss your cancer work:

	<u>usually</u>	<u>often</u>	<u>sometimes</u>	<u>rarely</u>	<u>never</u>
a) with other social workers?					
b) with other colleagues?					
c) outside the hospital? (please specify with whom)					

22. Does discussing your work help you? Please explain.

23. Would you be interested in other types of support?

24. a) If yes, can you suggest potential sources of support, such as peer groups, consultation, etc?

b) If no, can you say why not?

25. Is there anything else about your work with cancer, its stresses and how you cope with them that you can note here?

APPENDIX 2

CANCER SUPPORT AND TRAINING PROGRAM _ PARTICIPANT QUESTIONNAIRE

Please answer the following questions. All responses will remain anonymous and will be reported only in aggregate data.

1. What is your age, at your last birthday? _____
2. What year did you graduate from social work school? _____
3. How many years were you employed as a social worker (paid) prior to graduate school? _____
4. How many years were you employed as a social worker (paid) since graduate school? _____
5. How long have you been employed at New York Hospital? _____
6. Do you expect to be working at New York Hospital five years from now? _____ 6a. If not, what do you expect to be doing? _____

7. What would another agency have to offer you for you to leave your present job now? _____
8. Are you a CSW? _____
9. Are you an ACSW? _____
10. Which professional associations do you belong to? _____

11. Have you taken courses or training since your MSW degree? _____
If yes, please specify. _____
12. How often have you attended social work workshops or conferences outside your job? _____
13. What do you feel is your primary source of professional stimulation?
colleagues at New York Hospital _____ Supervisor _____ Professional
reading _____ Professionals outside New York Hospital _____
14. How many years have you worked with cancer patients? (Please specify prior to or after MSW degree) _____
15. How many cancer patients do you work with monthly? _____
16. What proportion of your workload does that represent? _____
17. Would you prefer a different patient population? (Please give reasons) _____

18. Would you accept an assignment where all the patients had cancer?

19. Do you feel knowledgeable about cancer? _____
20. Would you want more information about cancer? _____
 If yes, what kinds of information would you want? _____

21. Would you say that your work with cancer patients calls for a different level of intensity than work with others? (Check one)
 Much more intense involvement _____ Slightly more involvement _____
 About the same involvement _____ Slightly less involvement _____
 Much less involvement _____
22. How involved do you feel in your job? (Check one)
 Slightly _____ Moderately _____ Strongly _____
23. About how often do you get together with social work colleagues after work? Not at all _____ Occasionally _____ Frequently _____
24. How would you rate your interest in taking part in this program?
 Very interested _____ Fairly interested _____ Slightly interested _____
 Would have preferred not to participate _____
25. Please identify any relationships with members of this program that might be important for me to know in working with you as a group (e.g. close friend, former supervisor/supervisee, etc.). Include anything that you think might help or hinder the development of group cohesiveness. _____

PLEASE TURN TO PAGE 3 FOR THE LAST QUESTION.

26. What is most problematic to you in your work with cancer patients? Please answer as fully as possible and give at least one specific illustration in relation to a case or work situation.

APPENDIX 3

CANCER SUPPORT PROGRAM - ATTENDANCE RECORDS

<u>Date</u>	<u>Present</u>	<u>Seating Plan*</u>
10/15	7	
10/22	9	
10/29	7	
11/5	10	
11/12	8	
11/19	9	
12/3	7	
12/10	8	
1/14	8	

*A diagram was drawn after each session to record the seats chosen by participants. The investigator took the same seat at each meeting, positioned near the tape recorder and electrical outlet. Initially, participants tended to select the same seat from session to session, but the pattern became less fixed as they came to know each other.

APPENDIX 4

PRE AND POSTTEST OF ATTITUDES,
BEHAVIORS AND FEELINGSCANCER SUPPORT AND TRAINING PROGRAM

Please check one column
for each question.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. It tends to be harder to go to see cancer patients than other patients.				
2. The problems of cancer patients are more complex than those of other patients.				
3. Work with cancer patients, although demanding, is satisfying.				
4. There are many opportunities to be helpful to cancer patients because they have many problems.				
5. It is difficult to set realistic working goals with cancer patients.				
6. Work with cancer patients tends to be more stressful than other parts of a mixed assignment.				
7. Work with cancer patients requires specialized knowledge and skills.				
8. Most people that one works with don't want to talk about cancer patients.				
9. When you work with cancer patients you may need to be able to turn off your feelings at the end of the day.				
10. Feelings such as wanting to avoid cancer patients are best kept to oneself.				
11. It can be helpful to talk to someone else when work with a cancer patient is upsetting and depressing.				
12. It is possible to work as well with cancer patients as with any other patients.				

CANCER SUPPORT AND TRAINING PROGRAM--2

**Please check one column
for each question.**

1. I tend to see cancer patients less often than other patients.
2. My interviews with cancer patients are shorter than those with my other patients.
3. When I know a patient is dying, I tend to see him/her less often or for shorter interviews.
4. When a case is depressing to me, I find a colleague to talk it over with.
5. When I have difficulties in dealing with cancer, I seek supervisory help.
6. I turn to colleagues in nursing, medicine, and other areas for support.
7. If pressures of meeting a cancer patient's needs get to be too much for me, I focus my efforts on other parts of my job.
8. I seek information about the nature and effects of the specific type of cancer which each patient has.
9. I look for opportunities to attend programs about cancer.
10. When I am having trouble coping with a difficult and depressing case, I talk to friends outside my job.
11. I keep feelings of depression, anxiety or wanting to drop a case to myself.
12. I am able to listen to and concentrate on what cancer patients say.
13. I experience more exhaustion or fatigue working with cancer patients than with other patients.
14. I have trouble viewing cancer patients as individuals with unique problems.

[illegible]

CANCER SUPPORT AND TRAINING PROGRAM--3

Please check one column for each question.

	Always	Often	Sometimes	Rarely	Never
1. I am very nervous.					
2. I feel like crying.					
3. I feel like shouting.					
4. I feel like running away.					
5. I feel like hitting someone.					
6. I feel like doing something stupid.					
7. I feel like talking to myself.					
8. I feel like crying.					
9. I feel like shouting.					
10. I feel like running away.					
11. I feel like hitting someone.					
12. I feel like doing something stupid.					
13. I feel like talking to myself.					
14. I feel like crying.					
15. I feel like shouting.					
16. I feel like running away.					
17. I feel like hitting someone.					
18. I feel like doing something stupid.					
19. I feel like talking to myself.					
20. I feel like crying.					
21. I feel like shouting.					
22. I feel like running away.					
23. I feel like hitting someone.					
24. I feel like doing something stupid.					
25. I feel like talking to myself.					
26. I feel like crying.					
27. I feel like shouting.					
28. I feel like running away.					
29. I feel like hitting someone.					
30. I feel like doing something stupid.					
31. I feel like talking to myself.					
32. I feel like crying.					
33. I feel like shouting.					
34. I feel like running away.					
35. I feel like hitting someone.					
36. I feel like doing something stupid.					
37. I feel like talking to myself.					
38. I feel like crying.					
39. I feel like shouting.					
40. I feel like running away.					
41. I feel like hitting someone.					
42. I feel like doing something stupid.					
43. I feel like talking to myself.					
44. I feel like crying.					
45. I feel like shouting.					
46. I feel like running away.					
47. I feel like hitting someone.					
48. I feel like doing something stupid.					
49. I feel like talking to myself.					
50. I feel like crying.					
51. I feel like shouting.					
52. I feel like running away.					
53. I feel like hitting someone.					
54. I feel like doing something stupid.					
55. I feel like talking to myself.					
56. I feel like crying.					
57. I feel like shouting.					
58. I feel like running away.					
59. I feel like hitting someone.					
60. I feel like doing something stupid.					
61. I feel like talking to myself.					
62. I feel like crying.					
63. I feel like shouting.					
64. I feel like running away.					
65. I feel like hitting someone.					
66. I feel like doing something stupid.					
67. I feel like talking to myself.					
68. I feel like crying.					
69. I feel like shouting.					
70. I feel like running away.					
71. I feel like hitting someone.					
72. I feel like doing something stupid.					
73. I feel like talking to myself.					
74. I feel like crying.					
75. I feel like shouting.					
76. I feel like running away.					
77. I feel like hitting someone.					
78. I feel like doing something stupid.					
79. I feel like talking to myself.					
80. I feel like crying.					
81. I feel like shouting.					
82. I feel like running away.					
83. I feel like hitting someone.					
84. I feel like doing something stupid.					
85. I feel like talking to myself.					
86. I feel like crying.					
87. I feel like shouting.					
88. I feel like running away.					
89. I feel like hitting someone.					
90. I feel like doing something stupid.					
91. I feel like talking to myself.					
92. I feel like crying.					
93. I feel like shouting.					
94. I feel like running away.					
95. I feel like hitting someone.					
96. I feel like doing something stupid.					
97. I feel like talking to myself.					
98. I feel like crying.					
99. I feel like shouting.					
100. I feel like running away.					
101. I feel like hitting someone.					
102. I feel like doing something stupid.					
103. I feel like talking to myself.					
104. I feel like crying.					

1. I feel that my work is of no less value because a patient dies while I am working with him/her.
2. When patients I am working with die, I feel depressed.
3. The complexity of cancer patients' problems makes me feel helpless to intervene.
4. On days when most of my work is with cancer patients, I feel drained.
5. The complexity of a cancer patient's social needs makes me feel that I don't know enough to help.
6. I find that I identify strongly with some cancer patients.
7. I wish I could change to an assignment with fewer cancer patients.
8. I feel that someone else might do this kind of work better.
9. I feel that I become too involved with my cancer patients.
10. I feel relaxed and at ease with cancer patients.
11. I feel capable of helping cancer patients with their problems.
12. I feel more apprehensive or anxious about meeting cancer patients than about meeting other patients.

[illegible]

APPENDIX 5

SAMPLE RESPONSE TO QUESTION ON
MOST PROBLEMATIC ISSUE

In the initial research questionnaire, you were asked the following:

What is most problematic to you in your work with cancer patients? Please answer as fully as possible and give at least one specific illustration in relation to a case or work situation.

Your answer was:

1) Within the hospital system as a whole cancer is "brushed under the rug." Honest and open discussions between patients and hospital team rarely take place. Realistic alternatives are rarely given to patients -- therefore there is added confusion on patients' parts -- and double messages and avoidance behavior often the sole means of dealing with patients.

Example: Patient is terminally ill. Doctors will not discuss this possibility with the patient and/or family. We as social workers are hindered in helping patients deal with feelings and make plans.

2) There is no forum within the social work department where our feelings re work with cancer patients is discussed. Our own feelings of helplessness re medical course and impending death for patients.

Example: 70 year old woman terminally ill -- here from Peru -- no family. Patient depressed but able to express feelings and fears. I often feel overwhelmed with feelings of empathy and sorrow for her. Yet I, myself, have no outlet or support group to help me manage these feelings.

APPENDIX 6

Participant Evaluation of Cancer Support and Training Program

PLEASE BE SURE TO CHECK AN ANSWER TO EACH QUESTION. WHEN RESULTS OF THE EVALUATION ARE REPORTED, ALL NAMES WILL BE OMITTED. PLEASE ANSWER THOUGHTFULLY, KEEPING IN MIND THAT THERE IS NO "RIGHT" ANSWER. YOUR RESPONSES WILL PROVIDE UNDERSTANDING OF WAYS IN WHICH THE PROGRAM MIGHT BE MORE HELPFUL.

1. To what extent do you think the Cancer Support and Training Program achieved its goals of:

- a) increasing participants' knowledge and skills in relation to their work with cancer patients?

Not at all	Hardly	Somewhat	Quite a bit	Very much

- b) increasing participants' knowledge and skills in relation to coping with stress experienced in such work?

Not at all	Hardly	Somewhat	Quite a bit	Very much

- c) having participants identify stresses and problems in their work?

Not at all	Hardly	Somewhat	Quite a bit	Very much

- d) having participants offer solutions to the stresses and the problems identified?

Not at all	Hardly	Somewhat	Quite a bit	Very much

- e) having participants assist in planning the program of support and training?

Not at all	Hardly	Somewhat	Quite a bit	Very much

- f) having participants assist in planning for continuing peer group support beyond the program?

Not at all	Hardly	Somewhat	Quite a bit	Very much

2. How prepared do you feel now to cope with job stress related to cancer, compared to how you felt prior to the program?

Not at all Hardly Somewhat Quite a bit Very much

--	--	--	--	--

- a) If you feel better able to cope, please specify in what way.

- b) What do you think contributed to your increased ability to cope?

3. How necessary do you think a support and training program such as this one is for preparing staff to cope with the stress of working with cancer patients?

Not at all Hardly Somewhat Quite a bit Very much

--	--	--	--	--

4. How necessary do you consider peer support for those working with cancer patients?

Not at all Hardly Somewhat Quite a bit Very much

--	--	--	--	--

5. What did you like best about the program?

6. What did you like least about the program?

7. What value, if any, do you think a support and training program such as this one has for staff?

8. What recommendations would you make about this support and training program for the future regarding:

a) number of sessions _____

b) length of sessions _____

c) content _____

d) sequence of content _____

e) format _____

f) leader _____

g) participants (number, selection, etc.) _____

h) arrangements (time, location, etc.) _____

9. Additional comments about the program _____

APPENDIX 7

RANKING OF SIGNIFICANT THEMES

Some problematic issues and feelings expressed by members of the support group are:

- a) Overwhelming feelings of empathy and sorrow
- b) Hopelessness and helplessness about the medical course and the anticipated death of patients
- c) Feeling "dumped on" -- the target of the patient's anger when doctors have backed off
- d) Lack of resources for families in need
- e) Frustration and anger at not being able to provide what is needed
- f) Depersonalization of patients by the hospital system
- g) "Protection" of patients by their families and the breakdown in communication which results
- h) Society's continuing view of a cancer diagnosis as a death sentence
- i) Difficulty dealing with the uncertainty of prognoses
- j) Identification with a patient or family member
- k) Pessimism about patients' chances for survival -- even when the patient is optimistic
- l) Dealing with an angry patient by avoiding him/her
- m) Feeling that teamwork is supportive (to the worker)
- n) Lack of support on the job
- o) Being in the role of helper to doctors, nurses etc., and being unable to seek/receive support from them.

Please rank these issues and feelings in order of importance to you personally. List the items (as a,b,c etc.) in the table, below, with the most important as 1 and least important as 15.

- | | |
|---------|----------|
| 1. ____ | 9. ____ |
| 2. ____ | 10. ____ |
| 3. ____ | 11. ____ |
| 4. ____ | 12. ____ |
| 5. ____ | 13. ____ |
| 6. ____ | 14. ____ |
| 7. ____ | 15. ____ |
| 8. ____ | |

APPENDIX 8

CURRICULUM FOR THE PROJECT

A PROGRAM OF SUPPORT AND TRAINING FOR SOCIAL
WORKERS WORKING WITH CANCER PATIENTS
IN GENERAL HOSPITALS

CURRICULUM

The curriculum is planned on the basis of the following considerations:

1. The study's definition of support includes both the development of peer group mutual aid and cognitive aspects. Therefore, a training curriculum outline will be used as the basis for both learning of skills and development of peer support.

2. Curriculum content is derived from two sources: the researcher's expertise in the area of training in the field of cancer, and areas of need identified in the needs assessment.

Objectives

To provide information and resources which will enable participants to broaden their range of skills in work with cancer patients. To enable workers to develop a peer support system, based on mutual aid, which will include sharing knowledge and resources.

Content

Four lines of inquiry will be pursued:

a) The nature of cancer and its impact on patients, families and those who serve them. This involves content in the following areas:

1. Knowledge of the disease and its unique features
2. Knowledge of the range of treatments and their effects on life-style
3. Awareness of the special fears and fantasies associated with cancer, including cure and fatality statistics, etc.

b) The special social work needs of cancer patients and their families, related to factors such as:

1. Chronicity of the disease
2. Life-threatening nature of the disease
3. Mutilating effects of treatment
4. Changed life-style
5. Social stigma
6. Dying, bereavement and planning for surviving family members

Skills needed to work with the special needs of cancer patients will be reviewed. They include both counseling and advocacy, needed by patients as they come to grips with the task of developing coping patterns to adapt to the crisis of their illness, and as they seek essential services.

c) Obstacles to maximum social work participation in the care of cancer patients. These include: attitudes and feelings which interfere with the workers ability to give services; lack of particular knowledge and skills and lack of information about resources to

obtain training and support.

d) Peer group mutual aid and support networks.

The range of models for mutual aid and support will be reviewed and analyzed. Resource networks and support networks will be planned.

Outline of Sessions

- Session 1 Introduction. Development of a work contract with group members. Clarification of goals of the program, based on research goals and workers' interests.
- Completion of pre-test questionnaires to measure worker attitudes and behaviors.
- Sessions 2 - 4 Addressing specific knowledge gaps and skill deficits in the areas identified in content description above.
- Session 5 Assessment of progress, with feedback among all group members and the researcher. Development of continuing and new lines of inquiry.
- Sessions 6 & 7 Further knowledge and skill development with case material from participants as well as from resources of the researcher.
- Session 8 Summary and review, developing plans for future coping mechanisms. Identification of continuing needs and training requirements.

APPENDIX 9

EVALUATION OF THE MEASURES
USED IN THE PROJECTA. Measures of Programmatic
Impact

Attendance records and logs documenting content themes were adequate for the task of evaluating the program's actual contact with its participants. While attendance records demonstrated only that the workers had attended a majority of the sessions, the logs were detailed enough to provide evidence of active participation.

B. Monitoring by
Tape-recording

Although the presence of the tape-recorder caused some anxiety for participants, it did not appear to seriously hamper their participation, nor inhibit the development of important themes. Recording proved to be a highly productive method of capturing data for analysis of content themes, levels of activity and the achievement of program goals. While the investigator's log included much of this data, the tapes were additionally useful for expansion of the analysis, verification of themes and development of a more objective framework for the in-

vestigator's recollections as noted in weekly logs.

C. Pretest and Posttest of Attitudes, Behavior and Feelings

Although substantial data were generated by these measures and new directions for research were suggested, there were serious difficulties related to the validity and reliability of the measures. The measures were developed because standardized tests appropriate for this project could not be found. It is now evident that refinement is necessary in order to validate that items actually test for the findings intended.

Another significant problem of the measures was related to their sensitivity. It was not clear, with the very small population, that the changes reflected, such as a single participant changing a particular behavior, were significant of change resulting from the program. The instrument may not have been sensitive enough to demonstrate changes that took place in some areas. When such changes occurred as one shift in a more positive direction and one in another, they appeared to cancel each other out. Yet, the instrument was not sufficiently developed to make clear the potential significance of such superficially equivocal results.

D. The Most Problematic Issue

The instrument that recorded the most problematic issue generated data on many themes. It was both a

means of increasing knowledge about problems in the daily work of hospital social workers and a means for evaluating the impact of the program. Many responses attested to the group's impact on changing or modifying participants' attitudes, behaviors and feelings about their work with cancer patients. Such developments were useful in evaluating both expected and unintended effects of the program and also served to suggest areas for further research related to problems in cancer work and to coping behaviors used.

E. Ranking of Problematic Issues

This measure was valuable for illustrating the relative importance of problems cited as major concerns before and after the program. It permitted some assessment of the impact of the program on the participants' management of stress on the job.

Usefulness of the instrument was diminished by several factors. The list of fifteen items to be ranked was too broad. It was difficult for participants to establish priorities with such large numbers. It was similarly difficult to categorize the ranked items and examine the frequency with which they received priority as enduring concerns. An attempt to establish a distribution of that frequency was further complicated by overlapping categories. For refinement of the instrument, the categories should be fewer, more discrete and

exclusive.

F. Evaluation Questionnaires

These questionnaires generated substantial data about many aspects of the program. The findings permitted evaluation of the extent to which many program objectives had been achieved. The questionnaire also elicited useful information about participants' preferences for the program if it were repeated.

The evaluation would have been enhanced by specific questions about experiences of mutual aid and transfer of the group's effects to daily job functioning, as these were related to the central goals of the program.

BIBLIOGRAPHY

- American Association of Medical Social Workers. A Statement of Standards to be Met by Social Service Departments in Hospitals, Clinics and Sanatoria. Washington, D.C.: American Association of Medical Social Workers, 1949.
- American Cancer Society. Cancer Facts and Figures, 1981. New York: American Cancer Society, 1980.
- American Hospital Association. Social Work Staff Development for Health Care. Chicago: American Hospital Association, 1976.
- Apaka, Tsuneko K.; Hirsch, Sidney and Kleidman, Sylvia. "Establishing Group Supervision in a Hospital Social Work Department." Social Work 12 (October 1967): 56-60.
- Bales, Robert F. Interaction Process Analysis. Reading, Mass.: Addison-Wesley Co., 1950.
- Bandoli, Larry R. "Leaderless Support Groups in Child Protective Services." Social Work 22 (March 1977): 150-151.
- Bard, Morton. "The Psychological Impact of Cancer and Cancer Surgery." In Proceedings of the American Cancer Society's National Conference on Human Values and Cancer, Atlanta, Georgia, June 1972. American Cancer Society, 1973.
- Barstow, Linda F. "Working with Cancer Patients in Radiation Therapy." Health and Social Work 7 (February 1982): 35-40.
- Bartlett, Harriett. Social Work Practice in the Health Field. New York: National Association of Social Workers, 1961.
- Beach, David R.; Levine, Murray and Goldberg, Shepard. "Teacher Discussion Groups: A Community Mental Health Approach." International Journal of Social Psychiatry 19 (Spring-Summer 1973): 102-109.

- Becker, Howard S.; Geer, Blanche; Hughes, Everett C. and Strauss, Anselm L. Boys in White. Chicago: University of Chicago Press, 1961.
- Caplan, Gerald. Support Systems and Community Mental Health: Lectures on Concept Development. New York: Behavioral Publications, 1974.
- Caplan, Gerald and Killilea, Marie, eds. Support Systems and Mutual Help: Multidisciplinary Explorations. New York: Grune and Stratton, 1976.
- Caroff, Phyllis and Vigilante, Florence. "Age Specific Issues in Educating Professionals to Work with Terminally Ill Patients and Their Families." Journal of Gerontological Social Work 1 (Summer 1979): 333-340.
- Carter, Novia and Wharf, Brian. Evaluating Social Development Programs. Canada: Canadian Council on Social Development, 1973.
- Cartwright, Dorwin and Zander, Alvin. Group Dynamics. New York: Harper and Row, 1968.
- Chernesky, Roslyn. "A Training Program to Prepare Social Workers for Professional Review." D.S.W. dissertation, City University of New York, 1976.
- Cobb, Sidney. "Social Support as a Moderator of Life Stress." Psychosomatic Medicine 38 (September - October 1976): 300-314.
- Cohen, Arthur and Smith, R. Douglas. The Critical Incident in Growth Groups: A Manual for Group Leaders. California: University Associates Inc., 1976.
- Conkling, Virginia. Social Work Consultant, American Cancer Society. Interview, 10 September 1981.
- Cooper, Cary L. "Social Support at Work and Stress Management." Small Group Behavior 12 (August 1981): 285-297.
- Copans, Stuart; Krell, Helen; Gundy, John H.; Rogan, Janet and Field, Frances. "The Stresses of Treating Child Abuse." Children Today 8 (January-February 1979): 22-27.
- Daley, Michael R. "Burnout: Smoldering Problem in Protective Services." Social Work 24 (September 1979): 375-379.

- Davidson, Kay Wallis. "Evolving Social Work Roles in Health Care: The Case of Discharge Planning." Social Work in Health Care 4 (Fall 1978): 43-54.
- Domanski, Margaret; Lipiec, Kathleen; Rensel, Suzanne and Sherwin, Katherine. "Comprehensive Care of the Chronically Ill Cancer Patient: An Inter-Agency Model." Social Work in Health Care 5 (Fall 1979): 59-70.
- Encyclopedia of Social Work, 16th ed., 1971. Vol. 2. S.v. "Self-Help Groups," by Herbert Barish.
- _____. 17th ed., 1977. Vol. 2. S.v. "Self-Help Groups," by Alfred H. Katz.
- Epstein, Irwin. "Advocates on Advocacy: An Exploratory Study." Social Work Research and Abstracts 17 (Summer 1981): 5-12.
- Epstein, Irwin and Tripodi, Tony. Research Techniques for Program Monitoring and Evaluation. New York: Columbia University Press, 1978.
- Flanagan, John C. "The Critical Incident Technique." Psychological Bulletin 51 (1954): 327-358.
- Freudenberger, Herbert J. "Burn-Out: Occupational Hazard of the Child Care Worker." Child Care Quarterly 6 (Summer 1977): 90-99.
- Freudenberger, H.J. "Staff Burn-Out." Journal of Social Issues 30 (1974): 159-165.
- Garland, James A.; Jones, Hubert E. and Kolodny, Ralph L. "A Model for Stages of Development in Social Work Groups." In Explorations in Group Work: Essays in Theory and Practice, pp. 12-53. Edited by Saul Bernstein. Boston: Boston University School of Social Work, 1965.
- Gartner, Alan and Riessman, Frank. Self-Help in the Human Services. San Francisco: Jossey-Bass Publ., 1977.
- Gelfand, Bernard; Rohrich, Sandy; Nevidon, Pat and Starak, Igor. "An Andragogical Application to the Training of Social Workers." Journal of Education for Social Work 11 (Fall 1975): 55-61.

- Gitterman, Alex. "Development of Group Services." In Conference Proceedings on Social Work with Groups in Maternal and Child Health, pp. 15-21. New York: Columbia University School of Social Work and St. Luke's-Roosevelt Hospital Center, 1979.
- Glaser, Barney and Strauss, Anselm. Awareness of Dying. Chicago: Aldine Publ. Co., 1965.
- Gosling, Robert; Miller, Derek H.; Turquet, Pierre and Woodhouse, Douglas. The Use of Small Groups in Training. London: Grune and Stratton, Inc., n.d.
- Hallowitz, Emanuel. "Innovations in Hospital Social Work." Social Work 17 (July 1972): 89-97.
- Hamlin, Elwood R. II and Timberlake, Elizabeth M. "Peer Group Supervision for Supervisors." Social Casework 63 (February 1982): 82-87.
- Hare, Alexander. A Handbook of Small Group Research. New York: Free Press of Glencoe, 1962.
- Hartford, Margaret E. Groups in Social Work. New York: Columbia University Press, 1971.
- Hirsch, Sidney and Lurie, Abe. "Establishing a Hospital Social Service Department." Social Work 4 (April 1959): 86-99.
- Hirsch, Sidney and Shulman, Lawrence C. "Participatory Governance: A Model for Shared Decision Making." Social Work in Health Care 1 (Summer 1976): 433-446.
- Hung, Aileen. "Coping Behavior of Patients and Their Families to a Life-Threatening Illness (Brain Tumor)." D.S.W. dissertation, Columbia University, 1976.
- Kadushin, Alfred. "Games People Play in Supervision." Social Work 13 (July 1968): 23-32.
- Kahn, Robert. "Job Burnout: Prevention and Remedies." Public Welfare 36 (Spring 1978): 61-63.
- Kaplan, Barbara E. and Hurley, Frances J. "Head and Neck Cancer: A Threat to Life and Social Functioning." Social Work in Health Care 5 (Fall 1979): 51-58.

- Kaplan, Mildred Fine and Glenn, Anne. "Women and the Stress of Moving: A Self-Help Approach." Social Casework 59 (July 1978): 434-446.
- Katz, Daniel. "Preparing Public Agency Field Instructors." D.S.W. dissertation, City University of New York, 1982.
- Killilea, Marie. "Mutual Help Organizations: Interpretations in the Literature." In Support Systems and Mutual Help: Multidisciplinary Explorations, pp. 37-93. Edited by Gerald Caplan and Marie Killilea. New York: Grune and Stratton, 1976.
- Klagsbrun, Samuel C. "Cancer, Emotions and Nurses." American Journal of Psychiatry 126 (March 1970): 71-78.
- Kleiman, Mark Allen; Mantell, Joanne E. and Alexander, Esther S. "Collaboration and Its Discontents: The Perils of Partnership." Journal of Applied Behavioral Science 12 (1976) Special Issue on Self-Help Groups: 403-410.
- Klein, Roberta. "A Crisis to Grow On." Cancer 28 (1971): 1659-1678.
- Knowles, Malcolm S. "Innovations in Teaching Styles and Approaches Based upon Adult Learning." Journal of Education for Social Work 8 (Spring 1972): 32-39.
- Kolotkin, Richard A. "Preventing Burn-Out and Reducing Stress in Terminal Care: The Role of Assertive Training." In Behavior Therapy in Terminal Care, pp. 229-252. Edited by Henry J. Sobel. Cambridge, Mass.: Ballinger Publ. Co., 1981.
- Koocher, Gerald P. "Adjustment and Coping Strategies Among the Caretakers of Cancer Patients." Social Work in Health Care 5 (Winter 1979): 145-150.
- Kropotkin, Petr Alekseevich. Mutual Aid: A Factor of Evolution. New York: Alfred A. Knopf, 1925.
- Kübler-Ross, Elisabeth. On Death and Dying. New York: Macmillan, 1973.
- Larson, Charles C.; Gilbertson, David L. and Powell, Judith A. "Therapist Burn-Out." Social Casework 59 (November 1978): 563-565.

- Lee, Stacey. "Interdisciplinary Teaming in Primary Care: A Process of Evolution and Resolution." Social Work in Health Care 5 (Spring 1980): 237-244.
- Levine, Sol and Scotch, Norman A. Social Stress. Chicago: Aldine Publ. Co., 1970.
- Levy, Charles. Social Work Ethics. New York: Human Sciences Press, 1975.
- Levy, Leon H. "Self-Help Groups: Types and Psychological Processes." Journal of Applied Behavioral Science 12 (1976) Special Issue on Self-Help Groups: 310-322.
- Lohmann, Roger A. "Dying and the Social Responsibility of Institutions." Social Casework 58 (November 1977): 538-545.
- McCall, George and Simmons, J. L., eds. Issues in Participant Observation: A Text and Reader. Reading, Mass.: Addison-Wesley Co., 1969.
- Mailick, Mildred. "The Impact of Severe Illness on the Individual and Family: An Overview." Social Work in Health Care 5 (Winter 1979): 117-128.
- Maslach, Christina. "Job Burnout: How People Cope." Public Welfare 36 (Spring 1978): 56-58.
- Maslach, Christina and Pines, Ayala. "The 'Burn-out' Syndrome in Day Care Settings." Child Care Quarterly 6 (Summer 1977): 100-113.
- Mechanic, David. "Social Structure and Personal Adaptation: Some Neglected Dimensions." In Coping and Adaptation, pp. 32-44. Edited by George V. Coelho; David A. Hamburg and John E. Adams. New York: Basic Books, 1974.
- Miller, S. M. "The Participant Observer and Over-Rapport." In Issues in Participant Observation: A Text and Reader, pp. 87-89. Edited by George McCall and J. L. Simmons. Reading, Mass.: Addison-Wesley Co., 1969.
- Millett, Nina. "Hospice: Challenging Society's Approach to Death." Health and Social Work 4 (February 1979): 130-150.
- Milner, Clara Joan. "Compassionate Care for the Dying Person." Health and Social Work 5 (May 1980): 5-10.

- Nacman, Martin. "A Systems Approach to the Provision of Social Work Services in Health Settings: Part 2." Social Work in Health Care 1 (Winter 1975-6): 133-143.
- Nelsen, Judith C. "Support: A Necessary Condition for Change." Social Work 25 (September 1980): 388-392.
- Northen, Helen. Social Work with Groups. New York: Columbia University Press, 1969.
- Olsen, Katherine M. and Olsen, Marvin E. "Role Expectations and Perceptions for Social Workers in Medical Settings." Social Work 12 (July 1967): 70-78.
- Oppenheimer, Jeanette R. "Use of Crisis Intervention with the Cancer Patient and His Family." Social Work 12 (April 1967): 44-52.
- Patti, Rino; Diedreck, Elenore; Olson, Dennis and Crowell, Jill. "From Direct Service to Administration: A Study of Social Workers' Transitions From Clinical to Management Roles, Part I." Administration in Social Work 3 (Summer 1979): 131-151.
- Pearlin, Leonard I. and Schooler, Carmi. "The Structure of Coping." Journal of Health and Social Behavior 19 (March 1978): 2-21.
- Perlman, Helen Harris. "In Quest of Coping." Social Casework 56 (April 1975): 213-225.
- Peterson, Frances. "Teaching Undergraduate Social Work Students How to Help Others Maximize the Utilization of Social Welfare Resources in Bureaucratic Systems." D.S.W. dissertation, City University of New York, 1978.
- Pilsecker, Carleton. "Terminal Cancer: A Challenge for Social Work." Social Work in Health Care 4 (Summer 1979): 369-379.
- Pines, Ayala and Kafry, Ditsa. "Occupational Tedium in the Social Services." Social Work 23 (November 1978): 499-507.
- Pines, Ayala and Maslach, Christina. "Burn-Out in Mental Health Professionals." In Proceedings of the Second Annual Conference on Child Abuse and Neglect. Austin, Texas: Resource Center on Child Abuse and Neglect, 1977.

- _____. "Characteristics of Staff Burnout in Mental Health Settings." Hospital and Community Psychiatry 29 (April 1978): 233-237.
- Reid, Kenneth E. "Nonrational Dynamics of the Client-Worker Interaction." Social Casework 58 (December 1977): 600-606.
- Riecken, Henry W. "Memorandum on Program Evaluation." In Evaluating Action Programs, pp. 85-104. Edited by Carol H. Weiss. Boston: Allyn and Bacon, 1976.
- Riessman, Frank. "The 'Helper Therapy' Principle." Social Work 10 (April 1965): 27-32.
- Ross, Judith W. "Coping with Childhood Cancer: Group Intervention as an Aid to Parents in Crisis." Social Work in Health Care 4 (Summer 1979): 381-391.
- Schneiger, Frank. "The Worker Burnout Phenomenon: Implications of Current Research for the Child Protective System." Child Abuse and Neglect, Special Newsletter Supplement, I. Community Council of Greater New York, November 1978.
- Schoenberg, Bernard; Carr, Arthur C.; Kutscher, Austin H.; Peretz, David and Goldberg, Ivan K., eds. Anticipatory Grief. New York: Columbia University Press, 1974.
- Schwartz, Marc D. "Situation/Transition Groups: A Conceptualization and Review." American Journal of Orthopsychiatry 45 (October 1975): 744-754.
- Schwartz, Mary C. "Helping the Worker with Countertransference." Social Work 23 (May 1978): 204-209.
- Shulman, Lawrence. The Skills of Helping Individuals and Groups. Itasca, Illinois: F.E. Peacock Publ. Inc., 1979.
- Silverman, Phyllis R. and Murrow, Hope G. "Mutual Help During Critical Role Transitions." Journal of Applied Behavioral Science 12 (1976) Special Issue on Self-Help Groups: 410-418.
- Solkoff, Joel. "Learning to Live Again." New York Times, 4 June 1978, sec. 6, p. 100.

- Sontag, Susan. Illness as Metaphor. New York: Farrar, Straus and Giroux, 1977.
- Stonberg, Marion F. "Oncology." Health and Social Work Supplement to Vol. 6:4 (November 1981): 695-745.
- Streepy, Joan. "Direct-Service Providers and Burnout." Social Casework 62 (June 1981): 352-361.
- Suchman, Edward A. Evaluative Research. New York: Russell Sage Foundation, 1967.
- Sutherland, Arthur M. and Orbach, Charles E. "Depressive Reactions Associated with Surgery for Cancer." In The Psychosocial Impact of Cancer, pp. 17-21. New York: American Cancer Society, 1977.
- Taylor-Brown, Susan; Johnson, Kay Hannon; Hunter, Kathryn and Rockwitz, Ruth J. "Stress Identification for Social Workers in Health Care: A Preventive Approach to Burn-Out." Social Work in Health Care 7 (Winter 1981): 91-100.
- Teague, Doran. "Social Service Enterprises: A New Health Care Model." Social Work 16 (July 1971): 66-74.
- Topitzer, Gerald F. "The Effect of Psychosocial Factors on the Rehabilitation of the Cancer Patient." D.S.W. dissertation, Columbia University, 1975.
- Toren, Nina. "Semi-Professionalism and Social Work: A Theoretical Perspective." In The Semi-Professions and Their Organization, pp. 141-195. Edited by Amitai Etzioni. New York: Free Press, 1969.
- Tripodi, Tony; Fellin, Phillip and Epstein, Irwin. Differential Social Program Evaluation. Itasca, Ill. F.E. Peacock Publ. Co., 1978.
- Tripodi, Tony; Fellin, Phillip; Meyer, Henry J. The Assessment of Social Research. Itasca, Ill. F.E. Peacock Publ. Inc., 1969.
- Tuckman, Bruce W. "Developmental Sequence in Small Groups." Psychological Bulletin 63 (June 1965): 384-399.
- Turquet, Pierre M. "Leadership: The Individual and the Group." In Analysis of Groups, pp. 349-71. Edited by Graham S. Gibbard; John J. Hartman and Richard D. Mann. San Francisco: Jossey-Bass, 1974.

- U.S. Department of Health and Human Services. Office of Cancer Communications, National Cancer Institute. Coping with Cancer: A Resource for the Health Professional, eds. Barbara Blumberg, Mara Flaherty and Jane Lewis. NIH Publication No. 80-2080, 1980.
- Wattenberg, Esther. "Characteristics of Family Day Care Providers: Implications for Training." Child Welfare 56 (1977): 211-229.
- Weigel, Richard G. and Corazzini, John G. "Small Group Research: Suggestions for Solving Common Methodological and Design Problems." Small Group Behavior 9 (May 1978): 193-220.
- Weiner, Hyman J. "Communications Among the Professional Team." In Social Work in Maternal and Child Health: A Casebook, pp. 1-11. New York: Columbia University School of Social Work and St. Luke's-Roosevelt Hospital Center, Department of Social Work, Roosevelt Division, n.d.
- _____. "Demand for Rehabilitation in a Labor Union Population." D.S.W. dissertation, Columbia University, 1964.
- Weiss, Carol H. Evaluation Research. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1972.
- White, Robert W. "Strategies of Adaptation: An Attempt at Systematic Description." In Coping and Adaptation, pp. 47-68. Edited by George V. Coelho, David A. Hamburg and John E. Adams. New York: Basic Books, 1974.
- Whyte, William Foote. "Observational Field-Work Methods." In Research Methods in Social Relations, pp. 493-513. Edited by Marie Jahoda, Morton Deutsch and Stuart W. Cook. New York: Dryden Press, 1951.