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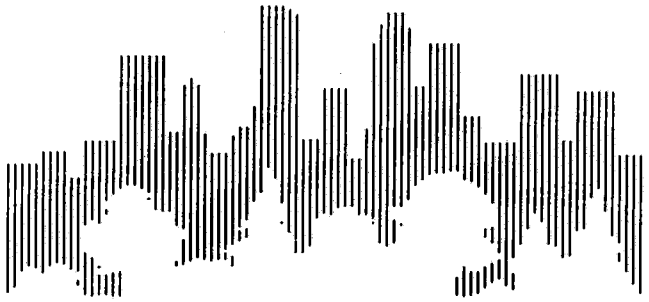

C • O • L • L • E • G • E

MASTERS IN SOCIAL WORK THESIS

Gena du Bois

An Exploration of Nursing Home Social Workers' Training and Support Networks in the Area of Death and Grief

1995

MASTER OF SOCIAL WORK
AUGSBURG COLLEGE
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MINNESOTA

CERTIFICATE OF APPROVAL

This is to certify that the Master's thesis of:

Gena E. du Bois

has been approved by the Examining Committee for the thesis requirements for the Master of Social Work Degree.

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AN EXPLORATION OF NURSING HOME SOCIAL WORKERS' TRAINING AND SUPPORT NETWORKS IN THE AREA OF DEATH AND GRIEF.

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ABSTRACT OF THESIS

AN EXPLORATION OF NURSING HOME SOCIAL WORKERS' TRAINING AND SUPPORT NETWORKS IN THE AREA OF DEATH AND GRIEF.

by Gena du Bois

April 1995.

This exploratory study was formulated for the purpose of collecting data to define and substantiate the phenomenon of "Grieve out," coined by Dick Obershaw of Burnsville, Minnesota. "Grieve out" will be defined as "...emotional investment...staff invests and never divest of the relationship" upon the death of the resident. The definition of burnout will be discussed as it is not dissimilar to "grieve out." This thesis is based on Doka's theories of disenfranchised grief, Bowlby's attachment and loss theory, and Vachon's occupational stress theory. It is based on these theorists that this work will focus on boundaries, supportive networks, and specific internal and external factors that may contribute to "grieve out." The latter term is distinct and the data was collected from rural and metropolitan social workers in Minnesota. There was at least a fifty percent response rate to this survey for either rural or metropolitan respondents. Data revealed resondents were not required to have knowledge of grief or death issues as a condition for their employment. In addition they did not receive regular professional supervision yet they were expected to assist with the grief process of fellow staff members. Respondents reflected a high affinity for furthering their knowledge base by continued educational forums and expressing a desire for increased information in this area.

CHAPTER 1

INTRODUCTION

"To everything there is a season, and time to every purpose under the heaven: A time to be born, and a time to die, ... a time to mourn, and a time to dance."(Ecclesiastes 3:1-4.)

This is an exploratory study of nursing home social workers training and support networks in the area of death and grief. The concern of this researcher is the adequacy of training in the area of death and grief given the nursing home social worker. There appears to be a push to maintain census and "fill-the-bed" once a resident has died. This may present immediate conflict for the individual social worker who has established an emotional connection to the resident who is now deceased. A healthy working relationship between the social worker and the resident has a balanced component of emotional attachment.

Over-investment and a lack of clear boundary definition may put the social worker at risk for a process called grieve out. Grieve out as defined by Obershaw will be used throughout this thesis to mean an "emotional investment...in which the staff invests and never divest of the relationship" upon the death of the resident.

Grieve out is defined as a chronic stressor to the worker who is coping with not only the limitations of the work setting but who needs permission to grieve for the deceased resident. Grieve out may also be the effect of poor emotional boundaries in which the resident is fulfilling the emotional needs of the social worker. In this way, the

elements of grieve out may be similar to those of burnout. However, the multiple losses and personal grief work that must be done to maintain the social worker's integrity are an essential component that recognizes grieve out as a possible component of burnout.

There are many types of grief. In his book on disenfranchised grief, Doka (1989) defines disenfranchised grief as that which is not allowed to be expressed or where the griever is removed from the grieving process. A key to disenfranchised grief is the alienation from the means of support that others who grieve receive by nature of the loss. Doka discusses

> 'grieving rules'-- that attempt to specify who, when, where, how, how long, and for whom people should grieve. Folta and Deck (1976) offer rationale for these rules: (1) the relationship is not recognized; (2) the loss is not recognized; and (3) the griever is not recognized. The underlying assumption is that closeness of relationship exists only among spouses and /or immediate kin. (Doka p. 239).

Bowlby's work on attachment and loss theories has a primary focus on children who are also disenfranchised grievers, and on what is considered pathological in the mourning process (Bowlby 1980). Bowlby asserts that there are three schools of thought on mourning: 'guilt or fear of retaliation, paranoid fear, and finally that of anxiety'. He continues to assert that " . . . there is a continuum in feeling between anxiety and despair...during grief, feelings often travel back and forth, now nearer to anxiety, now to despair." (Bowlby p. 27).

The result of the work of Doka and Bowlby is that a non-family member, the

social worker in the nursing home, in this instance is not given permission to grieve the death of the resident. Thus, nursing home social workers may experience disenfranchised grief. This grief process needs to be validated for the social worker and support needs to be offered as well as opportunities to recognize and to process the loss.

The concern of this researcher is that social work programs and nursing homes should provide social workers with adequate training in death and grief issues. Nursing homes should provide social workers with adequate training to perform their multiple and often conflicting roles. Vachon, drawing upon the occupational stress literature of Perlin and Schooler states that the social worker is aided by :

> ...three types of coping responses: those that change the situation out of which strainful experiences arises, those that control the meaning of the experience before stress occurs, and those that function to control stress. It was found that the caregivers coped by changing the situation out of which the strainful experience might arise by: developing control over certain areas of practice; having a personal philosophy of illness, death, and one's role; increasing education; establishing a team philosophy--support-building; staffing policies; administrative policies; formalized ways of handling decision-making; good orientation; and job flexibility. A coping response that *controlled the meaning of the experience after it occurred* but before the emergence of stress was the development of a sense of competence, control, and pleasure in one's work. Responses that functioned more for the *control of stress* itself after it emerged included: leaving the work situation, developing support outside the work situation, lifestyle management, having a sense of humor,

avoiding patients or families, using colleagues at work, and support groups. (Vachon p. 181).

This qualitative exploratory study is based on Doka's theory on disenfranchised grief, Bowlby's attachment and loss theory, and Vachon's theory on occupational stress. It will test the hypothesis that nursing home social workers who have supportive education and training concerning issues of death and grief and who have supportive professional networks are less likely to experience emotional boundary issues and to suffer from grieve out.

This study is organized in the following manner. Chapter Two will review the literature on burnout and issues of mortality, death and dying. The methodology of the study will be presented in Chapter Three. The findings will be discussed in Chapter Four and Chapter Five will reveal the study's conclusions. Finally Chapter Six will indicate recommendations of this thesis.

CHAPTER 2

REVIEW OF THE LITERATURE

This literature search focused on those sources that defined burnout and provided examples of research into the interpretation of burnout in the nursing home environment. The search further focused on mortality, death and dying, and the professional social worker's response to working with a population of elderly who have a high mortality rate and the resulting impact on the social worker.

Burnout:

Cherniss (1980) distinguishes burnout from turnover with respect to those who may become"burned out" yet do not leave the work setting. The author notes the conflict of internal and external stressors and learned helplessness. The three stages of burnout are stress, strain, and coping; all these stages are in terms of greater than normal strain and not just temporary strain or fatigue to the individual. Cherniss notes the responsibility of the organization to the worker in assisting with this process.

Heine (1986) discusses this area of burnout as it relates to the care of nursing home residents. The themes noted by this author are the high incidences of confusion as well as high dependency needs of the residents. Due to financial constraints, nursing home personnel are the most inexpensive and young. She goes on to note, "...staffing pattern(s), architectural design, and psychosocial programs in nursing homes are often inadequate to meet the demands of the increasing nursing home population of confused, dependent residents."(p. 14). She goes on to discuss options for dealing with this issue by offering venting sessions for employees to regularly discuss their frustrations but to

initiate their own "problem-solving process."(p. 16). Key areas of this research are "organizational climate, organizational policies, education/staff development, specific resident centered strategies and finally personal strategies."(p.16). She emphasizes that self care is essential to the worker as well as the resident's on-going "quality of life and quality of care." (p.18). Thus environmental stress is a given component of nursing homes today.

Maslach (1982) writes about burnout as "...a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who do " people work."(p.3). Maslach goes on to discuss this as that piece of the helping relationship, a stress level that is chronic in nature. In her work, she has created a highly utilized tool called the Maslach Burnout Inventory (MBI) . The phenomenon of burnout is not about "bad people," but rather a response by the worker to "situational sources of job-related, interpersonal stress."(p. 9). The author reframes the question that human service workers ask of themselves from whom, to what factors cause one to burnout (p. 12). Maslach goes on to point out how this is victim blaming to think that the individual is the problem and not the environmental factors in which s/he works. In her description of distancing behavior, Maslach describes the shift from the nurturing caregiver to an impersonal negative interaction that lacks feeling. There are "... four aspects of this relationship: the focus on problems, the lack of positive feedback, the level of emotional stress, and the perceived possibility of change or improvement." (p. 18). The author discusses the Freudian concept of countertransference which goes beyond empathy to note an over-identification of roles by the social worker. Boundary

issues are an integral part of the therapeutic relationship, Maslach notes that all relationships end. In the nursing home setting, this ending is often the death of the resident.

Landsbergis, (1988) discusses the usefulness of "Person-Environment (P-E) Fit theory" (p. 217) as this relates to the stressors of the staff position and the resources available to the worker toward problem resolution. Respondents to Landsbergis' survey were from hospitals and nursing homes in New Jersey. The significant point noted was the relationship in the variables of the study and the positive relationship of education to physical exertion and that of decision latitude. Landsbergis shows improved correlations between job dissatisfaction and the burnout scales, and that the concepts of burnout and job dissatisfaction are separate theoretical entities, in relation to the factors of strain, emotional exhaustion and depersonalization. Job demands are significant predictors of burnout. The person-environment fit theory seeks to answer the issue of burnout in a personality type.

Rusnac, & McNulty, & Moxley (1991) discuss key points as follows: Grievers are vulnerable individuals and this process begins before the individual has died through the funeral/memorial or death rituals to the time where they must make sense of the death. It lasts as long as it needs to last for that person.

Poulin & Walter (1993) engage in an exploration of the following methodology in their longitudinal study entitled: A national longitudinal survey of the National Association of Social Workers (NASW) and social workers belonging to the Gerontological Society of America (GSA) via mailed questionnaires regarding the issue

of burnout. The authors admit there are few longitudinal studies of the topic. This was a random sample of the NASW workers and all members of GSA. There was a response rate of 61.5% to the initial survey and 78.3% to the follow up survey. The measurement of burnout utilized Maslach and Jackson's (1981) Emotional Exhaustion Index of nine items on a seven-point scale. The independent variables included: organizational, client and personal variables. They found that: "Those who had high levels of burnout in 1989 tended to have high levels of burnout in 1990. Upon resurvey they noted that "two-thirds of the subjects did not change between 1989 and 1990." There is a significant zero-order correlation with job autonomy in burnout. This data supports the need for identifying the factors for burnout in specific areas, systems and organizations. The response rates suggest the professionals in these membership organizations perceive themselves to be in chronic stressful situations yet not sufficient to leave their job. This information is useful in that these individuals have a great potential for burnout. The results do not identify what coping skills keep these professionals from becoming stagnant.

Poulin & Walter (1993) cite that "Satisfaction with clients is significantly associated with burnout change," "age is not associated with change in burnout." It encompasses "four significant change variables (job stress, supervisor support, satisfaction with clients, and self-esteem) accounted for about 28 percent of the variance between the decreased and increased burnout groups." The authors continued "burnout appears to be a relatively stable phenomenon."... "job stress was the strongest predictor, it appears that burnout is associated with a number of organization, client, and personal factors." and "Two significant variables that emerged as important in decreasing

burnout...supervisor support and availability of organizational resources." The authors caution that the data is to be cautiously applied to all social workers as fewer than 20 percent were under the age of 30. One of the questions of burnout is if this phenomenon is applicable only to the new social worker with unclear boundaries or if it happens across all age groups regardless of experience level. The above four variables are not specific to the new worker.

Taylor-Brown, S., Johnson, K.H., Hunter, K., & Rockowitz, R.J. in their (1982) article, Stress identification for social workers in health care: A preventive approach to burn-out, approach this subject from "... an ecological perspective of social work (Germain, 1979)." The authors note their literature search observes the end result of burnout as "job termination." and the following: "Some of the untested stressors suggested in the literature include: role conflict (Daley, 1979), client characteristics (Koocher, 1979; Maslach, 1977; Pines, 1978), and working conditions (Daley, 1979). Koocher (1979) identified coping strategies utilized by health care workers working with cancer patients to reduce the effects of burn-out." (p. 92).

The secondary camp is that of the occupational stress literature, perceived as "...a continuum from personal to organizational stressors." The author goes on to site "A personal stressor confronting the worker as qualitative overload which is created by a job that requires skills the worker does not possess. This can produce symptoms of emotional and physical strain; job dissatisfaction, lowered self-esteem, high cholesterol and an increased incidence of coronary heart disease (French and Caplan, 1970)." (p. 92-93) These authors' study is from within an institution, the hospital, in which she notes

stressors of the "health team model" as rather inefficient and the environment as having a perception of being "'open'" yet conflicts in the "...ambivalent status of the eyes of those it serves (Wilson, 1976)" (p. 94). "Cooper (1978) and others have noted that one's relationship with one's colleagues can have a decisive impact on job performance and identified three critical variables: (1) rivalry, (2) office politics, and (3) social support systems."(p. 94) " Cooper (1978) found that better educated and higher paid workers receive more support from co-workers and experience less stress and strain, as also confirmed by French and Caplan (1973). " (p. 95). This work focuses on only those stressors related to the job. The authors suggestions are for those who develop courses for social workers and human services to consider stress identification and implementation of their tool in self assessment of job stress and seeking the career specialty that best fits that individual (p. 96-99).

Koeske & Koeske (1989) direct the reader into a new stream of thought as burnout need not be assumed to be related to an "excessive work load". The authors note that case load is not a synonym for work load. The authors state that " stress is postulated to be the mechanism by which work demands place unsupported and ineffectual social workers at risk for burnout. " (p.244)

The hypothesis by Jayaratne, Chess & Kunkel (1986) indicates a correlation that workers with high burnout scores tended to have feelings of "anxiety, depression, irritability, and somatic complaints and...less satisfaction with their jobs and lower self-esteem compared to workers who scored low on the burnout scale."(p. 53).

Anderson, J. C. (1992) is quoted " As a group, the Type-A individual neither

lives in extraordinarily stressful life circumstances or manifest obvious, apparent deficiencies in coping resources for managing the stresses they do encounter. Most studies that have gathered occupational data have found positive associations between Type-A scores and occupational level, higher occupational status, higher income at a younger age, occupational achievement and advancement." (Anderson (1992) p. 53). This has relevance in that a personality type is not specific to predicting future worker burnout as was thought at one time. This has relevance in that a personality type is not specific to predicting future worker burnout as was thought at one time.

This author J.K. Roberts (1982) presents a survey of the different burnout theorists including Occupational Hazard Theory, Transactional theory of Job Satisfaction-Dissatisfaction Theories, Herzberg's Motivator-Hygiene theory, Job Characteristics Model, Activation Theory, Career Stages Model, and finally the author's Life Management Model. The author notes that human service organizations differ qualitatively to business organizations. (Roberts, 1982, p. 60). The author proposes to define the human service organization as..."the uniting of a social system and a psychosocial-technical system with other resources to affect improved social functioning, and /or to identify, and reduce social deviance, through a series of interactions." (Roberts, 1982, p. 69-70). Systems Theory is described on multiple levels: " the individual's physical and emotional resources determine the upper limits of one's possible responses. Secondly the interactions with immediate family, intimate social network, or friendship community. Time, and its attendant changes by the life management model of burnout a dynamic one." (p. 76). "This study proposes to be an exploratory effort to

examine professional worker burnout as a work-life manifestation of a specific coping device. This device is made necessary as the demands upon an individual within the work environment exceed the total resources of one's satisfaction with one's work, family, friends (intimate social network), and one's own individual coping style. This is in contrast to the major theoretical positions that some individuals are inherently vulnerable to burnout." (P. 78.)

Mortality, Death and Dying:

Kubler-Ross (1969) wrote as a pioneer in work on death and dying in which she developed a conceptual framework in her five stages of grief as denial, anger, bargaining, depression, and acceptance. These stages were at first perceived to occur in a given order, but this is not the case and what has been established since Kubler-Ross' work is that the individual goes through these phases at their own pace and in their own time frame. The beauty of Kubler-Ross' work was that it is applicable to all cultures, ages and remains true to date. Other theorists have used other terms to value the individuals personal coping process on a micro level.

Bowlby (1960) book on loss is the third of three volumes of his work with children and the complex issues of attachment separation and loss. Although his work was with children and observation of their loss of a parent by separation or death the key is the universality of the information to all ages in the process of grief. His work values the instinctual nature of man.

Rando (1984) cites Lindemann's early work on the powerful phenomenon called "grief work"(p. 20). These words graphically describe one piece in the process of grief,

that being if the individual does not successfully complete their grieving for themselves, they will need to revisit this grief when another death or loss occurs in their life (p. 21). This process' duration and intensity of this process are entirely unique to the individual. The author goes on to explain the systemic issues that a grieving individual experiences which affect the home, work, the psychological changes and social disruption of roles and dreams that are forever altered by death. There are '...expenditure(s) of both physical and emotional energy. It is not less strenuous or arduous a task than digging a ditch.' (p.20). Rondo lists the phases of mourning as: numbness, yearning and searching, disorganization and despair, reorganization (p. 25). The author explores the foundations of grief work as taken from attachment theory (p. 21).

In 1964, Engel characterized the five features of grief: interruption of automatic, taken-for-granted aspects of living, attempts to refute, deny, and dispute the reality of the death, transmittal of various behavioral cries for help to solicit the response of others and express feelings of impotence, loss, and helplessness; attempts to construct a mental representation of the deceased to replace the physical presence; and personal, social and institutionalized experiences of grief that serve to detach the mourner from the dead and restore him to his place as a member of the social community."(p.25).

Freud, (1917) defined mourning as:

"'The reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, an ideal, and so on...It is also well worth notice that, although mourning involves grave departures from the normal attitude

to life, it never occurs to us to regard it as a pathological condition and to refer it to medical treatment. We rely on its being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful. (Freud, 1957, pp.243-244).'" (Rqndo, 1984, p. 23).

The healing process of grief requires that the individual is able to recognize that they are grieving and come to terms with the wide range of feelings that this process induces for as long as it takes that individual. Lindemann has given the following '...normal sequence of healing as ...1. shock and disbelief, 2. developing awareness, Restitution, Resolving the loss, idealization and the outcome...a year or more...' (p. 27). Parkes and Weiss (1983) state the three tasks which must be accomplished in order for recovery from grief to take place: 1. intellectual recognition and explanation of the loss, 2. emotional acceptance of the loss, and 3. Assumption of a new identity." (p. 27).

In the nursing home setting the social worker often has assisted the resident with a "social death" which is one of four types of death. The other types are psychological death, biological death and physiological death (Sudnow, 1967) (Rqndo 1984, p. 297). This involvement brings the worker in to the inner core and as a practitioner there is an emotional connection which permits the worker to assist the resident with their coping processes as social networks to the community diminish.

Rando describes the three broad categories of psychological loss as; avoidance, confrontation, reestablishment. (p. 27).

Sprung confronts the obvious problems workers in the nursing home setting face

in death anxiety as "...fear, denial, worry, concern, or anger." (p. 599). The worker must have done their own grief work in order to confront these fears and subsequently treat residents with dignity. The professional social worker not only must be aware of and capable of defining and clarifying grief work in the loss of the resident but, also, must understand how interlinked the worker is to personal and past bereavement issues. The social worker further must understand that current and future deaths may trigger these emotions.

Ray, Nichols & Perritt, note the defense mechanism of denial which cannot be used by professionals working with the terminally ill (1987). The authors note both the physical, emotional, or behavioral manifestations. In their conclusion the authors state the more members of the team involved with the hospice client the less stress to the care givers. This article is only a survey of nurses and social service workers in hospice settings. Although hospice research has not been included in this study in general this article is specifically inclusive of social workers and the function of the hospice team is not unlike the nursing home's interdisciplinary care conference and the function of these members.

Tout and Shama developed a 40-item burnout inventory with the following six characteristics: Client frustration, work setting frustration, tiredness, loneliness, work pressure, and colleague interaction. The responses to the Research inventory for burnout (RIB) was 132 possible characteristics into six key components. The subjects were 400 health and mental health professionals. The analysis is by two factor analyses. The reliability of this study was high and offers an overall reliability of 95% although it

is noted in the findings that colleague interaction is the weakest factor with this instrument.

Mary Vachon in her research with occupational stress in care givers of the critically ill and dying; uses the following definition of coping as ' the cognitive and behavioral efforts made to master, tolerate or reduce external and internal demands and conflicts among them' (6, p.233). Coping efforts serve to either manage or alter the person-environment relationship that is serving as the source of stress (problem-focused coping) or to regulate stressful emotions (emotion-focused coping). Coping efforts are made in response to stress appraisals that are continuously interactive throughout an encounter."(Vachon p. 179)

The author refers to the 'Person-Environment Fit Model' by French, J.R.P., Rodgers, W., & Cobb.S. (p.5). Adjustment as person-environment fit, the key traits of this theory are job satisfaction, occupational stress and that the situation is not static (p.5). These traits are relative to the individual within the scope of their position. The author not only emphasizes the stressors of job settings but the cognitive and emotional levels as integral links as coping mechanisms (p. 9). The author implores the reader to look at the composition of the individual care giver's demographic makeup, on a micro level are the internal factors and also on the macro level as in the external factors as this researcher notes this systems theory view that the demographic variables include age, sex, marital and family status, social class, and religion; and personality variables such as motivation for entering the field, personal value system, and personality and coping style of individual perception of stress (p.11). The values of the care givers was directly

related to the perception of the care giver to potential and the impact of how that individual might cope not necessarily religious (p.24). The author discusses in brief the locus of control as posed by Rotter (26), and that each person has individual assets and expectations to offer the position and '"the extent to which they control rewards, punishments, and other aspects of their lives.'" (p. 27).

Mary Vachon notes lifestyle management was utilized by social workers more than any other professional group as a coping mechanism, it is noted that this approach is a mixture of "both problem-solving and emotion-regulating," not withstanding the awareness of holistic integration of the person in both mind and body by, "regulating" and "attention to proper diet, sleep, exercise, avoiding the use of cigarettes, and judicious use of alcohol, caffeine, and other drugs." (p.192).

Mary Vachon like C. Anderson points out the "Type A Behavior Pattern ...polyphasic activity...free-floating aggression...time urgency...excessive drive..." (Vachon, 1987, p.25). These are the over achievers of the world the ones who seek fulfillment for a bottomless pit of something called personal achievement. The concept of burnout has many definitions and is known in all professions. Mary Vachon noted only (4%) in her study who equated this as a coping mechanism, her study groups were of individuals who came to her lectures and were mostly the more long term career individuals who had utilized adequate coping techniques in the health care professions. As noted by this literature review these individuals utilized coping mechanisms that were integral to their being and identify them as distinct entities. This researcher feels that in the helping professions, such as medicine one must act as if by reflex on so many parts of

the job; to be genuine without losing self and healthy boundaries. Another coping mechanism that Mary Vachon surveyed was distancing or avoidant behavior which included (11%) of her respondents. These avoidant behaviors can be both physical responses and psychological responses (p.199-200.)

The author goes on to discuss the (11%) who leave the work situation, not all of whom are burned out as some take regular vacations, sabbaticals, those nurses studied ages 25-35 were 1/3 as likely to stay in the work setting and those under this age grouping were expected to leave for reasons related to systems complaints (p.197). Again it is noted that the majority of the subjects of this study were nurses and were not perceived as relating to a singular incident. That several staff members might choose to leave at the same time causing voids within a system and a sense of loss by the care team," grief reactions, resentment, anger and sometimes feelings of inadequacy in those who remain." (p. 198).

Those (7%)who relied upon increasing their education as a coping mechanism tended to be emergency room staff, palliative care staff, and those over 30 and an appreciation for knowledge from other disciplines and less formal learning venues (p. 202). There were only (4%) who utilized support groups as a means of coping with the stressors of their work environment (p. 236) and (5%) who utilized outside support systems. Vachon points out that the younger care giver is more likely to use this mode than the experienced care givers. (p. 204) In the areas of oncology and chronic pediatric patients, counselors, nurses found this mode was utilized more often. (p. 204).

Mary Vachon seems to feel there is an under reporting of those care givers who

utilize outside support systems (5%), and only (3%) who use sense of humor. In filling the staffing needs of any team La Grand recommends the use of a set of hiring "guidelines for the helping profession and death education movement" (p. 220). It is essential in the identification, and most importantly the prevention of burnout for each member of the care team to have a team philosophy, to do team building and have a sense of team support (31%) identified this as a personal coping mechanism for job stress (p. 212-218). The issue of the right person and the right job should be thoughtfully observed and those individuals with a sense of "mission" need to be assessed in terms of realistic scope of the benefit of the position and proper boundary definition. There is a final caution that "life-event stressors" (p. 230) such as one's personal grief work must be attended to prior to hire and recommending the caregiver allow one year when there is a major death in their life (p. 220). Policies that empower workers to share the burden or rotate units in a patten can offer the professional new challenges (p. 221). On the positive side 'Veninga (23) states that in order to avoid burnout there must be commensurate financial and psychological rewards for responsibility because it grates to know one is working for less than others of commensurate responsibility....It is crucial to have recognition for a job well done and also to have the flexibility to take time away from clients or to spend time with clients if that would be an effective job reward.' (p. 224).

The internal environment must be conducive to patient care and (12%) of those surveyed attested to the fact that strong colleague cohesion was a coping mechanism (Shaffer, M. (1982). Life after stress. New York: Plenum.) "'When people are happy

and enjoy working together, the positive emotional climate generated by their interaction makes work pleasurable and satisfying.'"if not "'...people sense it and begin to reflect the attention in their work or in their relationships with co-workers" (p. 227). In order to provide the care giver a greater sense of control (12%) identified the formalization of the decision-making process as a means of coping with job stress in the work place. The author notes the literature which supports the rationale for this approach, but not why more care givers did not mention policy or ethics in terms of their decision-making processes. (p. 228).

Vachon, from the occupational stress literature indicates "...developing control over certain areas of practice; having a personal philosophy of illness, death, and one's role; increasing education; team philosophy--support-building; staffing policies; administrative policies; formalized ways of handling decision-making; good orientation; and job flexibility. A coping response that controlled the meaning of the experience after it occurred but before the emergence of stress was the development of a sense of competence, control, and pleasure in one's work. Responses that functioned more for the control of stress itself after it emerged included: leaving the work situation, developing support outside of the work situation, lifestyle management, having a sense of humor, avoiding patients or families, using colleagues at work, and support groups. Table 7" (p. 181). John Ruskin said "In order that people may be happy in their work, these three things are needed. They must be for it, they must not do too much of it, and they must have a sense of success in it" (p. 183).

Sixty-four percent of Mary Vachon's participants noted personal coping

mechanisms which assisted them in managing stress, of these mechanisms, 36% were environmental. (p.180). Those mechanisms which were emotion-regulating included "...having a sense of competence, control or pleasure in work; developing a personal philosophy of illness, death, or one's role; avoiding or distancing from patients either physically or psychologically; developing support outside the work situation; lifestyle management; having a sense of humor; talking to colleagues at work; and participation in support groups." (p. 180). The key component noted by this study, was that one type of coping mechanism was not more effective for a certain group, rather there must be a balance of the problem-solving and emotion-regulation (p. 181).

In summary, Vachon focused on the "seasoned" health care worker, and found that coping mechanisms are on a continuum that is unique to each individual as well as the work team as exhibited by 64% of Vachon's participants utilizing personal coping mechanisms and of these 34% were environmental. Also 12% used staff cohesion/support and 12% used a given problem-solving mechanism to manage job stress.

CHAPTER 3

METHODOLOGY

This is a study of social workers in Minnesota nursing homes. This master list consisted of 444 facilities which was obtained by the Minnesota Department of Health in October 1994. The researcher then divided this master list into rural and metropolitan area facilities. This resulted in a total of 290 rural nursing homes and 130 metropolitan nursing homes. Included in this were all facilities which inferred by their title that they had nursing home beds. Fourteen hospitals that have extended care units or imply that in their name were included. For the purpose of this study, hospice units were not included such that the focus remain upon social workers in nursing homes. It should be noted that residents in nursing homes may be covered under a hospice program, a team concept already employed in the nursing home environment for specifically those with terminal conditions and a life expectancy of less than six months.

Respondents were chosen by simple sample method, selecting every fifth nursing home from each list. This resulted in mailings to 58 or 1/5 of the rural nursing homes; 43 or 1/3 of those in the metro area. Mailings were sent to the following rural counties Aitkin, Beltrami, Big Stone, Cass, Clearwater, Chippewa, Chisago, Crow Wing, Faribault, Filmore, Freeborn, Grant, Goodhue, Houston, Itaska, Jackson, Kanabec, Kandiyohi, Lake, Le Suer, Lyon, Martin, McLead, Mille Lacs, Morrison, Nickollet, Nobles, Norman, Olmstead, Ottertail, Pipestone, Polk, Pope, Red Wood, Renville, Rock, Sterns, Scott, St. Louis, Steele, Todd, Winona, Wright, Yellow Medicine. Metropolitan counties included Anoka, Dakota, Hennepin, Ramsey, Scott, and Washington.

The Sampling Procedure:

There was a total mailing of 101 questionnaires. A cover letter was addressed to the Director of Social Services who was asked to pass the letter and questionnaire for completions by a social worker in that nursing home. A self-addressed stamped envelope was included in the packet to ensure confidentiality. The completed and returned questionnaire was considered implied consent and no signatures were requested. The respondent was assured that her/his participation, or failure to participate, would not be shared with their employer. Separate colored questionnaires were used to differentiate between rural and metropolitan respondents. The questionnaire was pretested on a small group of social workers for greater reliability. The list of respondents and all data were locked in a file, the key to which, was held by the researcher.

The questionnaire contained 45 questions, including multiple choice, short answer and a Likert scale or check list. The questionnaire was organized in the following manner: demographic information, job experience, type and frequency of supervision; adequacy of supervision; the role of admissions tasks as a percentage of time; emotional investment with residents; physiological symptoms of grief by self-assessment; intensity of these feelings; family involvement with resident's death; evaluation of closure to both the resident and the family; closure as a factor of the social worker's grieving process; utilization of hospice philosophies; the social worker's role in staff grieving; competence with grief management; evaluation of support systems of the worker both internal and external; self-assessment of current "grief work," boundary definition; number of hours

worked weekly as a stressor, training in death and grief work prior to hire, the availability of standard mental health services to the worker; worker's perception of grief workshops, and satisfaction rate.

Data collection and findings will be discussed in the following chapter.

CHAPTER 4

FINDINGS

There was a total response rate of 51% (n=52) of the facilities which received the questionnaire. Of the 48 questionnaires sent to rural homes had the individual response rates was 50% (n=29). The rate of response from metropolitan nursing homes was 53% (n=23). The responses revealed the following demographics: Of the rural respondents, 97%(n=28) were women and 3%(n=1) were men. In the Metropolitan area nursing homes 96%(n=22) of the resondents were women, and 4%(n=1) were of the men.

The respondents had the following professional training: 72% (n=21)of rural social workers were BSW level and 28% (n=8) were social service designees. In the metropolitan nursing homes, 65% (n=15) were BSW, 26% (n=8) were social service designees, and 9% (n=2)MSW's.

From both rural and metropolitan areas, the respondents were predominantly female, 97% (n=28) of whom are rural and 96% (n=22) of whom are metropolitan. In this career setting only 2% (n=2) were male. Over all 62% (n=18) rural and 37% (n=9) metropolitan respondents, identified this to be their first and only social work position.

The social workers in both settings desire additional information on grief and death issues, while 79% of rural, and 78% of metropolitan respondents wanted additional information as reported in question 44. Eighty-two percent (n=19) metropolitan and 83% (n=24) rural respondents assist either directly or indirectly by sanction with staff grief. These workers learn this information through their curricula and seminars.

In terms of the philosophy of nursing homes, rural respondents stated 69% (n=20) were non-profit, 28% (n=8) for-profit, and 3% (n=1) were church affiliated nursing homes. In the metropolitan nursing homes: 52%(n=12) were for-profit, 43%(n=10) were non-profit and 4% (n=1) were church affiliated.

Respondents were asked their job title. The Director of Social Service was asked to give this survey to a colleague for completion. In the rural setting 22% (n=15)of social workers identify themselves as the Director of Social Service, an indication that they are the only social worker in that nursing home. Of the rural respondents, 14%(n=4) were designees. However, it is noted that of the metropolitan nursing homes: 70% (n=7) were BSW/MSW social workers, and 43%(n=11) were the Director of Social Service. Of these Directors, 30% (n=3) were designees (See the glossary). The total number of social work designees in metropolitan social work positions was: 26% (n=6).

In the area of their current position: rural nursing homes 52% (n=15) indicated they had eleven to twenty years at their current position, 38%(n=11) of whom had been at their current position for six to ten years, 21%(n=6) two to three years, 17%(n=5) four to five years, 14% (n=4) eleven to twenty years, and only 3%(n=1) were in their first year. In the metropolitan nursing homes 74%(n=17) of the respondents had five or less years in their position, 35% (n=8) two to three years, 30% (n=7) were in their first year, 30% (n=7) respondents had six to ten years experience, 9% (n=2) four to five years. There were no metropolitan social workers who had more than ten years at there current position.

In terms of the rural social worker's total social work experience: 69%(n=20) had

more than five years experience, 38% (n=11) six to ten years, 31% (n=9) had five years or less career experience, 24% (n=7) eleven to twenty years, 14% (n=4) two to three years, 14% (n=4) four to five, and 7% (n=2) had over twenty years experience in social work in all, 3%(n=1) had one year or less. For metropolitan nursing homes total career experience, 52%(n=12) were up to five years, only 48%(n=11) had more than 5 years total social work experience, 30%(n=7) six to ten years experience, 22%(n=5) two to three years, 17%(n=4) four to five years, 17%(n=4) eleven to twenty years experience, 15%(n=3) responded this was their first year.

Social worker satisfaction was measured on a lickert scale of one to five with five being "dissatisfied." Rural responses were: 24% (n=7) a two, 24% (n=7)a three, 21%(n=6) one, 69%(n=20) one, two and three combined, while 7%(n=2)a four, 7%(n=2) a five were dissatisfied and a total of 14%(n=4) gave less than a three rating. Finally 21%(n=6) felt this question was not applicable. Metropolitan social workers stated: 70%(n=16) were content to neutral in their position prior to hire, 30%(n=7) a two, 22%(n=5) a three, 17%(n=4) answered n/a, 17%(n=4) one, 13%(n=3) a four, 0% dissatisfied.

Respondents identified the source of their professional supervision as follows: rural social workers stated: 59%(n=17) utilized the administrator, 14%(n=4) BSW's, 14%(n=4) LICSW's, 7%(n=2) other and 7%(n=2) did not respond to the question. In the metropolitan nursing homes the following supervision arrangements were made; 30% (n=7) went to a BSW, 30%(n=7) went to an MSW, 26%(n=6) went to an administrator, 13%(n=3) went to an LCSW/LICSW, 4%(n=1) went to a nurse, and 4%(n=1)stated

other as a psychologist. The second part of this question related to payment of supervision if it is not available in the setting, 38% (n=11)not applicable, 28%(n=8) did not respond to the second part of this question, and 7%(n=2) responded no, and finally 3%(n=1) answered "other" noting supervision was complete and not required. In terms of payment of professional supervision, the metropolitan respondents noted the following results: 48%(n=11) offered no response to this question, 22%(n=5) no, 22%(n=5) weekly, 0% affirmed they paid for a professional supervision.

Rural responses to the frequency of supervision: 48%(n=48) recieved this as needed. 28%(n=8) do not have supervision, 14%(n=4) met weekly, 3%(n=1) met twice a month, 3%(n=1) met quarterly, 3%(n=1) met yearly and , 0% monthly. Of those rural respondents who do not have professional supervision, 10%(n=3) had a BSW or 3%(n=1) had a BA in Human Services. The metropolitan respondents response to frequency of supervision: 39%(n=9) stated this was utilized on an as needed basis, 26%(n=6)met monthly, 22%(n=5) met weekly, 9%(n=2) do not have supervision, and 0% responses for yearly, twice a month, or quarterly.

Overall the respondents felt that as a result of supervision they were better able to perform their job in the following ratios: 41%(n=12) of rural respondents responded yes, 28%(n=8)responded no, 24%(n=7) felt this was not applicable, and 3%(n=1) responded that it was some other reason. Metropolitan respondents, when asked the same question: 57%(n=13) responded yes, 30%(n=7) responded no, 13%(n=3) felt this was not applicable, and 4% (n=1) felt it was some other reason such as identifying that they had a greater level of education than their supervisor.

In the admission process families and the resident must be aware of their rights, all charges and who are their care givers. In some nursing homes the admissions process is completed by one department, this questionnaire asks if the social worker has this responsibility or not and recieved the following responses of the rural recipients; 86% (n=25) do all of the tours, 10% (n=3) do them sometimes, 3% (n=1) only in the absence of the admissions staff. This means that 97% (n=28) of the time the social worker in the rural setting does the tour and the admissions process. Of those who do this with a frequency of "sometimes" or more, all were the Director of Social Services and 3% (n=1) a medical social worker. 41% (n=12) of those who do tours all the time are the Director of Social Service and possibly the only social worker in the building. An additional 41% (n=12) are social workers by training who perform this role. The remainder, includes 3% (n=1) chaplain and social work as a dual role. When the Metropolitan respondents were asked regarding their role with tours and admissions functions: 43% (n=10)responded all the time, 26% (n=6) performed this sometimes, 17% (n=4) acted only when admissions staff are absent, 9% (n=2) responded with other or never as they have admissions departments. The purpose of this question is to establish patterns in the social worker's ability to maintain healthy work-home boundaries. It appears that this is an expectation in both the rural and metropolitan settings and there is a problem for social workers to set this limit. It seems from these statistics 41% of the rural and 21% of the metropolitan nursing home social workers spent greater than a quarter of their work weeks putting in overtime. Only 3% (n=1) identified themselves as a part-time worker.

Of those rural respondents who spent time in admissions functions: 48% (n=14)

spent up to 25% of their time, 31% (n=9) spent up to 50% of their time, 10% (n=3) spent up to 75% of their time and 10% (n=3) had zero involvement, 0% responded that admissions functions were more than 75% of or their only responsibility. Likewise those respondents who spent time in the admissions functions in the Metropolitan area were noted have spent: 65% (n=15) a quarter of their time, 17% (n=4) 26-50% of their time, 13% (n=3) zero, 4% (n=1) 51-75% of their time, and 0% spent 76 % or more of their time.

Regarding the perception that the social worker identifies with their emotional involvement to the practitioner relationship, rural respondents stated the following; 62%(n=18) Frequently, 24%(n=7) Sometimes, 14%(n=4) Always, and 0% social workers responding to Rarely or Never. Similarly Metropolitan responses to their emotional involvement as practitioner: 43%(n=10) did so frequently, 43%(n=10) did so sometimes, 9%(n=2) did so always, 4%(n=1)did so rarely, 0% never acted in this manner.

The following physiological signs were chosen by rural respondents, who where asked to check all those experienced after the most recent death:

72%(n=21) felt relief,

41%(n=12)experienced fatigue,

28%(n=8) had poor concentration,

17%(n=5) had headaches, 17%(n=5) were reluctant to see clients, 17%(n=4) stated this was other,

7%(n=2) tardiness,

3%(n=1) agitation, 3%(n=1) lack of appetite, 3% (n=1)stomach problems,

3%(n=1) problems sleeping,

0% increased use of drugs/alcohol,

The Metropolitan respondents were also asked there responses to the most recent resident death:

57%(n=13) poor concentration, 57%(n=13) relief,

22%(n=5) other; including crying or sadness, 22%(n=5) Fatigue,

13%(n=3) problems sleeping, 13%(n=3) reluctance to see clients,

9%(n=2) agitation, 9%(n=2) no response, 9%(n=2) Headache,

0% lack of appetite, 0% stomach problems, 0% tardiness, 0% increased use of drugs/alcohol.

Social workers were then given a self-assessment question if the intensity of these feelings had changed in the last month, the rural response was as follow: 76%(n=22) rural respondents no, 14%(n=4) yes, and 1%(n=3) no answer. Metropolitan responses were as follows; 78%(n=18) no, 13%(n=3) yes, 9%(n=2) no response.

Rate the frequency of family visits of the most recent death on a likert scale from daily "1" to no family visits "5". The rural social work respondents stated: 55%(n=16) had daily visits, 17%(n=5) had a five, no family visits, 7%(n=2) a two rating, 7%(n=2) a three rating, 7%(n=2) a four rating. Then the Metropolitan respondents; 57 %(n=13) rate of 1 as daily visits, 9%(n=2) a two, 9%(n=2) a three, 9%(n=2) a four, 4%(n=1)no family visits and 9%(n=2) other. These are classic signs that grief is occurring for the social worker.

During the most recent progressive extended death at the nursing home, the social

worker is asked to rate the family involvement on a likert scale from one to five, if one was "supportive" and five "unable to cope." Of those rural respondents: 52% (n=15) had supportive family, 24%(n=7) gave a two, 7%(n=2)gave a three, 3%(n=1) gave a four, 0% responded they were unable to cope, and 3%(n=1) responded with"other." The Metropolitan respondents scored as follows; 39%(n=9) a one as supportive, 30%(n=7) gave a two, 17%(n=4) gave a three, 9%(n=2) responded with "other": as no family involvement, and 4%(n=1) unable to cope or non-supportive family, 0% checked four.

The next question inquired if closure was attained. For rural respondents: 59%(n=17) responded yes, 24% (n=7) identified the situation as anticipatory grieving, 14%(n=4) responded with "no" and 0% checked other. Metropolitan respondents noted : 61%(n=14) yes, 30%(n=7) anticipatory grieving occurred as it was a long death, 13%(n=3) no, and 4%(n=1) other. for which the social worker was unable to "say goodbye as it was a sudden death."

Respondents were then asked if this closure was a factor in their personal grieving. Rural respondent stated: 62%(n=18) yes, and 31%(n=9) no, 0% other. Metropolitan responses noted; 57%(n=13) responded yes, 26%(n=6) responded no, and 17%(n=4) responded to other or no answer.

The closure issue was then asked in terms of the family and rural respondents stated the closure was as follows: 59%(N=17) had closure with the family, 17%(n=5) felt somewhat, 14%(n=4) had none, and 3%(n=1) did not answer, although one aside noted, "There were no prior death's that a family was not involved". For the Metropolitan respondents; 83%(n=13) yes, 17%(n=4) somewhat, 9%(n=2) no family, 13%(n=3) no,

4%(n=1) no response.

When asked if the social worker must remove the resident's belongings once they die, rural respondents stated the following:. 45%(n=13) sometimes, 28%(n=8) frequently, 21%(n=6) rarely, and 0% never or always. Metropolitan response: 35%(n=8) rarely, 26%(n=6) sometimes 13%(n=3) always, 13% (n=3) frequently, and 13%(n=3) never.

The social worker was asked if deaths are more difficult to accept when you are not able to have closure with the family or if there is no family. Those rural respondents felt this to be difficult with the following frequency: 55%(n=16) sometimes it is difficult, 17% (n=5) frequently, 10% (n=3) that it is never difficult, 7%(n=2) that it is rarely, and 3% (n=1) stated the difficulty was related to some other reason, 0% it was always problematic. Metropolitan responses rated these problematic closures came in the following frequency; 65%(n=15) sometimes, 13%(n=3) never, and 13%(n=3) rarely, 9%(n=2) frequently, 4%(n=1) always.

For ever greater clarity the respondents were asked if deaths were more difficult to accept without closure with the resident Rural Social workers responded: 7%(n=2) always, 10%(n=3) sometimes, 62%(n=18) sometimes, 14%(n=4) never, and 0% never. The Metropolitan social workers stated; 4%(n=1) always, 17%(n=4) frequently, 61%(n=14) sometimes, 4%(n=1) never, and 13%(n=3) rarely.

Each respondent was asked if they have a hospice program or utilize their philosophy in your nursing home. All rural and metropolitan social workers know what this concept is and utilize it. The rural workers replied: 34%(n=10) sometimes,

28%(n=8) frequently, 24%(n=7) always, 7%(n=2) never, and 0% for rarely or never. Similarly the Metropolitan respondents; 52%(n=12) frequently, 30%(n=7) sometimes, 13%(n=3) always, there were 0% responses to: Never, Rarely, and Other.

Respondents were asked if they were expected to assist with staff grief. Rural social workers stated; 45%(n=13)yes,. 38%(n=11)felt this was indirectly expected, 10%(n=3) were not expected to do this, 3%(n=1) felt otherwise. In the group of Metropolitan respondents; 52%(n=12) felt this was indirect, 30%(n=7) stated yes, and 17%(n=4) were no expected to perform this role in the nursing home.

On a scale from one to five, respondents were asked their comfort level with assisting staff with bereavement, if one is very comfortable and five is uncomfortable. Those rural respondent state the following replies: 28% (n=8) a two, 28%(n=8) three, 24%(n=7) very comfortable, 10%(n=3) a three, 3%(n=1) no answer, 0% are uncomfortable. In the Metropolitan nursing homes of this same question respondents gave the following; 39%(n=9) three, 30%(n=7) very comfortable, 13%(n=3) two, 9%(n=2) four, 9%(n=2) other; no answer or depending upon the relationship to the individual. 0% felt uncomfortable with this area.

Respondents were asked which of the following concepts was utilized at your the facility when a resident is dying. It is noted that these numbers do not equal 100% since respondents are to check all applicable answers. Rural respondents noted the following services:

86%(n=25) Pain management, 86%(n=25) non-aggressive treatment, 86%(n=25) pastoral care,

83%(n=24) allow family vigils,

41%(n=12) volunteers,

38%(n=11)sensory stimulation,

31%(n=9) notify staff for the purpose of closure,

7%(n=2) staff diary for the bereaved,

3%(n=1) other, had a hospice room.

The same question was asked of Metropolitan respondents with the following results:

96%(n=22) Pain management,

87%(n=20) non-aggressive treatment, 87%(n=20) pastoral care,

83%(n=19) allow family vigils ,

43%(n=10) notify staff for the purpose of closure,

39%(n=9) volunteers,

22%(n=5) sensory stimulation,

13%(n=3) other,

9%(n=2) staff diary for the bereaved.

Nursing homes do not all have their own chaplain so the respondents were asked and the rural recipients stated; 45%(n=13) yes, 34%(n=10) had local churches come to provide this ministry, 31%(n=9)have no chaplain. The Metropolitan respondents were asked this as well; 52%(n=12) replied yes, and 48%(n=11) have local church involvement, 13%(n=3) have no chaplain.

Respondents were asked the frequency of funerals/memorial services at the nursing home, the rural respondents noted; 59%(n=17) had a monthly service, 45%

(n=13) have them as requested by the family, 28%(n=8) have them as requested by the resident, 7%(n=2) offer them yearly, 7%(n=2) have them as requested by staff, and 52%(n=15) offer the following other options: once, every quarter, no chapel, none, for each resident, given at the time of death, also held just after the death with the body present, when planned by the therapeutic recreation department, and for all deaths. The Metropolitan responses revealed the following; 39%(n=9) as requested by family, 35%(n=8) as requested by the resident, 35%(n=8) monthly, 17%(n=4) as requested by staff, and 26%(n=6) Other; including (9%(n=2) rarely, 4%(n=1) always offered), 13%(n=3) not an issue, 0% yearly.

The respondents were asked when they experience grief related to the death of a resident, what of the following supports they utilize. The rural respondents:

34% (n=10) stated "other" as: a local pastor, a co-worker, family support, hospice, the administrator or director of nursing,

24%(n=7) a social worker,

21%(n=6) chaplain,

17%(n=5) the charge nurse,

14%(n=4) none are available,

7%(n=2) an aide, and

10%(n=3) no response.

The Metropolitan responses to the supports utilized after a resident's death:

48%(n=11) other; [There were 26%(n=6) who did not indicate who they went to for this support in their indication of this response; 4%(n=1)family and

17%(n=4) friends within/ outside the nursing home, and 4%(n=1) staff],

43%(n=10) monthly,

35%(n=8) the charge nurse,

17%(n=4)chaplain,

9%(n=2) none,

4%(n=1) an aide.

Respondents were asked to check all the following terms which describe their emotions at this time. The rural respondents noted:

28%(n=8) loss of energy,

24%(n=7) change in concentration,

17%(n=5)Unmotivated,

10%(n=3) reluctance to come to work, 10%(n=3) frequent headaches,

7%(n=2) guilt bout the job, 7%(n=2) change in sleeping patterns.

The same question was asked of the Metropolitan respondents with results as follows;

61%(n=14) other;

57%(n=13) none or no comments,

22%(n=5) loss of energy,

13%(n=3)Unmotivated, 13%(n=3) change in concentration,

13%(n=3) reluctance to come to work,

9%(n=2) change in sleeping patterns,

0% frequent headaches, 0% guilt bout the job, 0% feeling like a failure, or

4%(n=1) "This is the best job I've ever had lots of support and emotionally

healthy people."

With regard to the regularity of vacations, rural respondents noted the following data; 66%(n=19) said yes, 17%(n=5) said no, 10% (n=3) responded they do so sometimes. The second part of this question asked with what frequency these respondents took their vacations. The rural respondents stated; 41%(n=12) they did so yearly, 38%(n=11) at other times to include the following, (quarterly, twice a year, sporadically, thrice a year, as needed), 10%(n=3) did not respond, 0% monthly. The Metropolitan responses revealed the regularity of vacations as; 65%(n=15)said yes, 26%(n=6) said sometimes, 9%(n=2) said no. In regard to frequency of vacations those metropolitan respondents stated they did so on the following basis: 48%(n=11) yearly, 43%(n=10) other; 4%(n=1) monthly, 4%(n=1)a day every couple of months, 4%(n=3) twice a year, and 4%(n=1) every two years.

Respondents were asked to denote if there vacations had a pattern. 59%(n=19) of rural social workers took several days at a time, 34%(n=10) weeks at a time, 17% (n=5) just around the holidays, 17%(n=5) other as a day now and then long week-ends or PRN for mental health, 10%(n=3) as needed for child care, 0% rarely. Of metropolitan responses 65%(n=15) took several days at a time, 30%(n=7) just around the holidays, 22%(n=5) weeks at a time, 13%(n=3)rarely, 13%(n=3) other, such as special occasions, and 7%(n=4) as needed for child care.

In relation to boundaries, the respondents were asked if they took work home while on vacation, the rural results showed; 69%(n=20) no, 21%(n=6) sometimes, 3%(n=1) yes. For the Metropolitan responses they stated; 70%(n=16) no, 26%(n=6)

sometimes, and 4%(n=1) yes.

Respondents were asked if they accepted business calls while they are at home, to which the rural respondents stated: 62%(n=18) occasionally, 14%(n=4) never, 10%(n=3) often, 10%(n=3) other; including seldom, none and vacations are taken out of town. Likewise the Metropolitan responses to this question showed; 52%(n=12) never, 35%(n=8) occasionally, 9%(n=2) often, and 0% other.

Respondents were asked the frequency of their over time hours. 34%(n=10) of rural respondents never worked over 40 hours, 28%(n=8) did so a quarter of the time, 14%(n=4) did so half the time, 10%(n=3) did so three quarters of their time and 7%(n=2) did so all the time. This means 31%(n=9) spend fifty percent of each normal work week the social worker put in overtime. Of the Metropolitan respondents stated : 35%(n=8) never performed overtime, 9%(n=2) 100% of their time, 9% Other(4%(n=1)% Rarely, 4%(n=1) work only part-time), 4%(n=1) 50% of the time, 4%(n=1) 75% of the time.

The following responses were given by respondents when asked if the administrator understood and encouraged the staff to seek education on grief and death. The rural respondents answered: 72%(n=21) yes, 17%(n=5) no, and 3%(n=1) not applicable. Metropolitan respondents answered: 65%(n=15) yes, 26%(n=6) no, 9%(n=2) other.

Prior to employment at the nursing home, respondents were asked if, and where they had received training in the area of death, dying and grief, the rural respondents stated; 52%(n=15) BSW curricula, 45%(n=13) in-services, and 14%(n=4) Other including the following: (hospice contract training, internship, and college classes for a

respondent who was non-BSW; and finally 10%(n=3)of those surveyed had attended seminars. Of the Metropolitan responses; 62% yes, 29% no, 10% other not consistently or unsure.

These respondents were asked if the nursing home offered death and grief training as a part of the orientation, the rural respondents stated: 55%(n=16)a no, 41%(n=12) responded this was not during training but at a later date, and 3%(n=1) yes, while 3%(n=1)answered other, which included an annual inservice on grief death and dying. It is not clear who was in charge of this seminar, if the social worker provided the information, the nursing home or an outside speaker. From the Metropolitan responses; 52%(n=12)answered no, 13%(n=3) answered yes, 13%(n=3) stated it was provided at a later date not during training, but at an inservice, 0% other.

The respondents were asked if they received grief training as a contingency to employment, to which the rural respondents checked: 75%(n=22)said no, 10%(n=3) felt this was not applicable, 7%(n=2) yes. The Metropolitan responses also noted; 65% (n=15)as no and 30%(n=7) no response, 4%(n=1) as a yes.

Competency was addressed by asking each respondent if they felt they had adequate training as noted by the rural respondents: 66%(n=19) yes, 14%(n=4) no, and 14%(n=4) Other identified: a desire for more, this was learned through personal spirituality, and as a continual need to be more effective in this area, 7%(n=2) I recieved some training that was insufficient. Then the Metropolitan responses noted: 65% (n=15) yes, 13%(n=3) checked they recieved some training which was insufficient, 13%(n=3) no, and 9%(n=4) other; expressing a desire for more or that this was through

personal experience.

During stressful times, respondents were asked if their supervisor was available to provide professional support. The rural respondents gave the following replies: 62%(n=18) said yes, 21%(n=6) said no. For the Metropolitan responses; 74%(n=17)said yes, 17%(n=4) checked other; (sometimes, or inconsistently, and occasionally). 4%(n=1) said no.

This survey attempted to assess the availability of mental health services such as an employee assistance program for staff members under the benefits program. Those rural respondents answered: 41%(n=12) no, 38%(n=11) yes, 21%(n=6) that the current benefits do not include mental health services, 7%(n=2) offered no answer, 0% had no benefits for employees. Of the Metropolitan respondents who were asked about these same benefits; 61%(n=14) said yes, 30%(n=7) said no, 0% no health benefits, 4%(n=1) of the respondents noted that benefits do not include these services.

As a follow-up to the above question, respondents where asked if the services were available in the community should they be offered to those who did not have mental health benefits; and rural respondents stated: 48%(n=14) yes, 17%(n=5) no, 17%(n=5) not applicable, 7%(n=2) unknown. This same issue of availability was asked of the Metropolitan respondents; 74%(n=17) said yes, 22%(n=5) stated this was unknown, 4%(n=1) no, 0% not applicable.

The survey asked respondents if they wanted more training workshops in this area, and for the rural respondents: 79%(n=23) said yes, 14%(n=4) made comments such as: "There are lots offered. In the area of complex family situations, for nurse aids,

as an educational component for facilitator training, " This was followed by 10%(n=3)who stated no. The Metropolitan responses; 78%(n=18) said yes, , 17%(n=4) made comments: 4%(n=1) no answer, 17%(n=4) want more, and finally 9%(n=2) said no.

Question 45: On a scale from one to five, if one is satisfied and 5 dissatisfied, respondent were asked their level of current job satisfaction. Of those rural respondents: 55%(n=16) were satisfied, 17%(n=5) gave a two, 10%(n=3)gave a three, 3%(n=1) gave a four, and 0% were dissatisfied. Finally the Metropolitan respondents were also asked to rate their job satisfaction with the following statistics: 22%(n=5) were satisfied, 30%(n=7) gave two, 39%(n=9) gave a three, 13%(n=2) gave a four, and 0% were dissatisfied or a five. The only additional comment given this researcher were those 4% who provided this researcher with an offered to assist with any further questions and she was very pleased with her position and supportive network.

CHAPTER 5

ANALYSIS OF THE DATA

Based on the response rates 51% rural and 53% metropolitan nursing home social workers had completed and returned the questionnaire, indicative of the interest of the respondents in the topic of grief. A response rate of this size indicates issues of death and grief are of significant importance to the nursing home social worker. This study has high internal validity due to a statistically significant response rate. This is not an exhaustive list.

In the literature search Rando addressed the stages of grief that individuals go through and she notes the intensity and duration to be unique, one of the phases of this process is that reorganization which as evidenced by these respondents physiological symptoms of grief to be indicative of the internal processing of grief. It should be noted that this survey did not attempt to identify if this was in any way relative to a current or past personal grief issue. This thesis did not delve into transference as a sub-topic which is a component of supervision, which analyzes the delivery of the service of social work. Do factors of this situation trigger internal emotions in the worker that effect the options or clarity of the problem and the best possible solution? In essence how can this be done better? thus the art of social work incorporated the persona into the delivery.

These respondents had a strong desire to work with the elderly and did so as evidenced by the high retention. this researcher was surprise by the high number of metropolitan social work designees primarily because they have greater access to supports, educational opportunities, and there are a greater number of social workers in

the metro area for the number of positions. This might give reference to lack of community that is more prevalent in a rural area. The depth of experience of rural nursing home social workers is especially significant. It was expected that the metropolitan nursing homes would not have great depth of experience as noted by zero social workers with more than 10 years in the nursing home setting. There are limited social workers in nursing homes with MSW training, The nursing home arena does not demand the MSW for advancement as do some other agencies or the hospital setting. Perhaps, nursing homes do not pay enough to attract and retain MSW's. Another possible reason for not pursuing an MSW might be access to programs, cost justification, or personal motivation. Finally, the title medical social worker in Minnesota often means hospital social work, which may imply a shared role between hospital and nursing home.

Data indicates that social workers in Minnesota nursing homes do not initially have sufficient training on grief and death issues but they are able and willing to seek this through seminars, and training programs such as hospice. Based on these results and the longevity of the workers in this field it is clear that there is a strong desire for many social workers to work with the elderly and they choose this early in their careers. As the population at this time is aging and there will be a surge in the numbers of services to the elderly as the "baby boomers" age, this study has sufficient reliability for future planning.

In both rural and metropolitan nursing homes there is a need for access to professional supervision on a regular basis to alleviate the apparent stressors to prevent "grieve out." Most rural social workers see their administrator as providing their professional supervision when they do have it and then contradict this by stating they do

not routinely have supervision or have supervision only on an as needed basis. In Minnesota, supervision is a requirement for only a given number of years at the BSW level which may be the reason for this response. The statistic that 48%rural and 39% metropolitan respondents recieved their supervision as needed, might mean that this was a flexible situation that they had frequent consultations, yet infers they were not required to have supervision and so it was not something they needed or utilized often given the options frequency of the question.

The questionnaire inquires as to the social worker's perception of an administrator's understanding of grief. It is not clear from the data that there is any clinical training to indicate that an administrator is appropriate to provide this type of supervision which is in no way similar to an update of the day to day operations of the department. Also, none of the respondents stated the source of their training on death and grief issues, which may reflect on the limited questions in this survey. It is not clear if the social worker who responded that their nursing home had a yearly training, or if in fact the same social worker was expected to perform this inservice.

For both metropolitan and rural nursing homes 30% and 45% respectively were expected to assist with staff grief. The depth of this intervention may be a factor in the social worker's "grieve out" or out right competency. Professional grief work is within the scope of the social worker's position. This research identified the employers expectation, by the 82% (n=43) respondents who felt a duty to perform this task. Future studies might pursue this issue and survey other care givers in the nursing home setting.

One potential stressor is that 52% metropolitan and 38% of rural respondents were

"indirectly" expected to assist with staff grief. Not only is the worker a disenfranchised griever as noted by Doka, but they may also have a role in the nursing home which is ambiguous by nature as noted here. This is an important to note that, both rural and metropolitan respondents, 44%(n=25) stated that grief training was not a requirement; yet 82% stated that they were expected to help their grieving peers. The fact that 51% (n=27) of social workers surveyed worked in nursing homes which do not have mental health supports for their employees is a significant component of the work environment and employee satisfaction; and if those same workers wanted services 12%(n=6) would be unable to access them locally. Thirteen percent (n=7) are not aware of the existence of local mental health services. This may be a sign that there are few to no resources in the area. The other stressors are the requirements to "fill-the-bed" after a death, and inadequate disengagement, or mourning the loss of a resident causes disenfranchised grief, as defined by Doka's "'grieving rules'" (Doka p. 4).

It is of special concern that some rural social workers had limited-to-no professional supervision as was evidenced by this study. While, 28%(n=8) BSW/MSW rural social workers had professional supervision, 70% (n=16) of metropolitan social workers had BSW/MSW supervision, and 4%(n=1) a psychologist. One of the crucial keys to supervision is the issue of transference, to maintain client objectivity which leads to proficiency of skills, and worker competency.

Respondents from rural nursing homes noted a rating on a scale from one to five a response of greater than three 10% (n=3) who were more dissatisfied in their former position. Furthermore, in their current positions only 7%(n=2) scored their level of

dissatisfaction as less than three. The metropolitan nursing home social workers similarly, had only 13%(n=3) toward worker dissatisfaction prior to hire as a four rating, and who at this time rate their job satisfaction as 13%(n=3) at a rating of four.

Another potential stressor is the expectation of the social worker to perform not only the case management function but also perform the admissions roles as in tours and processing the multitude of papers for a completed admission. The admission process is regularly managed by 52%(n=15) rural and 43%(n=10) metropolitan social workers.

The fact that Minnesota social workers underutilized appropriate professional supervision, is an example of an insufficient coping mechanism for increased job competency. This exemplifies one way in which nursing home social workers might decrease their physiological and emotional symptoms of grief by increasing their access to professional supports. From the statistics as to fluctuations in emotions over the last month, it appears that 76%(n=22) of the rural and 78% (n=18) metropolitan social workers, choose psychosocial responses indicative of grief responses, loss of motivation, loss of energy, lack of concentration, change in sleeping patterns or eating patterns, headaches, guilt, or reluctance to come to work. As a follow-up to those physiological symptoms, such as headaches or lack of appetite, respondents were then asked about the closure and their personal grieving process, which will be discussed in greater depth under the area of boundaries.

The respondents were asked the frequency of their level of emotional attachment to residents. All responded that they had some level of this attachment despite non-social work training of 28%(n=8) of rural respondents and 22%(n=5) are metropolitan

respondents. It seems that social workers are better advocates for their clients than for themselves as 28% (n=8) of rural respondents and 30%(n=7) are metropolitan by self-assessment feel that their supervision was not meeting their professional needs, had physiological symptoms and expressed concern for the issue of closure with the resident. It is also true that the families of both rural and metropolitan respondents had significant responses that this was indeed a factor in the social worker's personal grief process. These are examples of internal stressors. The questionnaire sought to determine a few of the external stressors through questions such as the role of social worker to peers, to family members, and job tasks such as the removal of the deceased resident's clothing, when and if a vacation can be initiated, the frequency of vacations, the ability to set limits with staff on phone calls recieved at home and work done at home, through maintenance of proper boundary distinction, and availability of mental health services. The fact that 41% of rural and 21 % of the metropolitan nursing home social worker worked overtime greater than 25% of the time seems to be a sign that with such regularity of work demands that there is justification for more part-time positions to deal with excessive work loads. For those nursing homes with greater numbers of residents with no family involvement, 17 % rural nursing home social workers identified and 4% metropolitan this factor is a significant stressor and for those nursing homes that might as a result be better able to identify this as a source of stress to the team and seek additional staffing as a result of this need. This potentially is also a stressor to other members of the care team. An example of which is the ambiguous task that has no specific assignment to any position in the nursing home like removal of the deceased resident's belongings especially

one with no family. The question as to the amount of time involved in admission functions seeks to address one of the role stressors for the nursing home social worker. In terms of systems theory this is not an exhaustive list of environmental stressors as individuals are affected by an unknown, unpredictable number of stressors.

Although there are numerous ways for the social worker to manage their own ongoing grief processes, an area of caution lies in the informal counsel to both families and fellow staff members this is an ambiguous area for the worker to maintain both professional boundary distinctions and the clinical assessment skills of the program. In the hospice setting boundary distinction and assisting in identification and support of staff grief is a vital component of a healthy team. This tool asks for respondents to identify personal physiological signs of grief related to the last resident death as a means of correlating their awareness of their grief. The list included classic signs of grief occurring for the social worker.

Limitations:

The data collection tool must be considered for face value validity and whether the researcher may generalize the data to other groups. This research shows there is a direct correlation. This questionnaire was created by this researcher and has several questions with two parts to them which may have been confusing to the respondent. Also several question need revision especially in the clarity of the likert scales. This tool seeks to assess the emotions of the respondent, and responses to grief by self-assessment, as well as respondent self-assessment of job satisfaction, which may be a limitation of the study. Regarding the questionnaire this tool was created by this researcher and thus

there are limits to generalizing results to groups other than Minnesota nursing home social workers. This questionnaire was to be handed to a non-Director of social services yet in a small department with an admissions coordinator the only professional social worker might be the director. This situation might alter the results if completed by the admissions staff member, and in this way be a limitation of the implementation and resulting data. It has limited validity in relation to the source of symptoms expressed by self-assessment to be in fact, especially those directly correlated to a nursing home resident's death or other life stressors, be it intrapsychic or external

From the list provided by the Minnesota department of health it is not clear whether a facility is indeed a skilled nursing home rather than a board and care home a lodge or other community living program of care. The importance of this lies in an expected standard of environmental components and regulations for all participants in the study.

In Mary Vachon's study 26% of the occupational stressors were identified as environmental work stressors, the respondents were noted to be physicians, nurses and other health care workers who manage ambiguity (p.75). Bowlby notes the pathology of mourning, called grief, and those symptoms when individuals are not allowed to grieve, then take on this form, yet continue to loss themselves in the care giver role which Bowlby terms "'projective identification.'" (p. 157).

The work philosophy was assessed by the respondent's answer to for-profit, non-profit, or church affiliated nursing home. This was a close ended question that did not allow inquiry as to if the nursing home was fulfilling their mission statement. This is an

area that clearly could be more fully explored in terms of tool adaptation. In retrospect this researcher, might have asked about the nursing home's current ability to fulfill its mission statement or a more direct question to the respondent in self-assessment form.

Vachon suggests that educational forums need to be orchestrated to meet the needs of the participants. The results herein reveal the need for greater educational programming, an indication they are experiencing signs of "burnout." Since these social workers are unable to equate themselves as disenfranchised grievers and access appropriate supervision, it is probable they are at risk for "grieve out." The presentation of this survey might be impetus enough for some social workers to consider increased supervision and educational opportunities on this issue.

The issue of counter transference was not addressed in the scope of this paper and it can be noted that this may be a contributing factor to "grieve out," of the worker who has not successfully completed the necessary personal grief work. It is not clear if the rural and metropolitan social workers seek out support from fellow social workers. This researcher feels that the rural respondents to this questionnaire show the ability to seek support and may see this as an informal function rather than as a consultation and supervision.

The results prove that nursing home social workers suffer similar physiological and psychological symptoms of burnout as noted by other researchers of health care workers of the critically ill and dying. (Vachon 1987).

CHAPTER 6

CONCLUSIONS & RECOMMENDATIONS

This research was an exploratory study and for this reason there are format issues that herein will be addressed for future adaptation as well as the hope that future study will expand and continue to pursue issues for professional social workers in Minnesota nursing homes. One such example of a format issue are for those questions with likert scales should be put in a format with a label for each number. On a scale from one to five the number three should be clearly noted as neutral. This questionnaire could be adapted to survey other health professionals on a smaller scale questionnaire as modified for profession specific issues and licensure or training requirements from nurse aids to administrators. Other groups to be studied would be social workers in hospitals and hospice programs, as they are exposed to the dying and critically ill individuals and they might benefit from focused programming.

From review of the literature there were limited articles with data specific to nursing home social workers as a group, yet it is clear that the role of the social worker on the health care team is not solely for the patient. In addition to this role, it is an expectation that the social worker assist the health care team in their mental health as a group by maintaining proper boundary definition with vulnerable groups, such as vulnerable patients and their families. Although it is necessary to ask who is the client, in terms of general systems theory, each client is connected to a family formally or informally and the coping skills of the family system impact the clients served and thus must be taken into account. The pursuit of the area of role ambiguity and an awareness

for practitioners to advocate for themselves and seek training opportunities that will assist them to be mentally and physically healthy is a primary goal of this thesis on "grieve out."

It appears from the data in this questionnaire that there is the expectation for the social worker to attend to the grief needs of fellow staff members by direct sanction or indirectly, despite no such requirement for grief training prior to hire. The individual counseling skills required for proper referral of grief issues should not be underestimated. It is for this reason that this researcher encourages Minnesota nursing home social workers to pursue this additional training as well as supervision.

The current occupational statistics on health care professionals as a group, shows that the greater the educational level the more likely the individual is to maintain their own mental health and not burnout. This was noted by Lefcourt's discussion of locus of control, (Lefcourt 1982, p.31),(Vachon p. 27), or the "messiah complex" by Sprung (p. 600) which puts the social worker in a position to resolve all problematic issues for not only the resident but also staff members. One of the biggest mysteries, in worker role ambiguity is the issue of mourning which has no baseline, but rather each person has their own "normal" range. Despite the high incidence of anticipatory grieving by social workers,, 30%(n=7) of metropolitan and 24%(n=7) of rural Minnesota nursing home respondents, this group assisted nursing home social workers in closure. Rondo has written on the topic of anticipatory grief, as stated above, there is no "normal" path for mourning as it is an individual process (Rondo 1986). Poulin & Walter perceive burnout on a continuum and indicate the two key predictors of this phenomena as supervisor

support and availability of organizational resources (Poulin & Walter (1993).

In Mary Vachon's study 26% of the occupational stressors were identified as environmental work stressors, the respondents were noted to be physicians, nurses and other health care workers who manage ambiguity (p.75). Bowlby notes the pathology of mourning, called grief and those symptoms when individuals are not allowed to grieve, than take on this form, yet continue to lose themselves in the care giver role which Bowlby terms "projective identification." (p. 157). The purpose of incorporating Bowlby's work herein is to identify the universality of grief to all ages and as Kubler-Ross' work that it is a process not which is not unique to any one culture. All groups have their rituals and the individuals' progress is a process of their own duration and intensity.

Vachon noted that social workers utilized a lifestyle management process which incorporates the two concepts of "problem-solving and emotion regulating" (p.192) as key components and she highlighted the fact that occupational stress is not a static condition such that like grief work requires more than a formula that will work for each person. It is the adaptability and the desire of the individual to resolve their own problems given the personal coping skills and resources of each individual. The "emotion-regulating" (p.192) element Vachon refers to is a basic component of social work, such that the individual social worker may not perceive this as something that they do per se as the art of social work is much like the manner in which one walks. Walking is done every day and yet each person does this basic function but with their own style, pace and almost without thinking. This skill, the art of social work is difficult to

measure or assess much less to distinguish as a component of grief work for the worker and test on a questionnaire. Despite the fact that social workers in health care now must be licensed or grandpersoned in, this requirement does not establish a baseline for knowledge on any one particular area as social workers bring a wealth of resources from each area of interest and experience. At issue is the availability of current resources for each given community, such as the usefulness of a county by county directory of resources offered by the Minnesota Department of Health. This list should not be limited to agencies as there may be qualified individuals willing to offer and provide these services. In addition, this list of resources would assist in preparing social workers who are sought out to provide grief counseling for colleagues /co-workers.

This study has high internal validity due to statistically significant response rate. The results prove that nursing home social workers suffer similar physiological and psychological symptoms of burnout as noted by other researchers of health care workers of the critically ill and dying (Vachon 1987). This was not an exhaustive list.

The fact that there are so few MSW's in the nursing home setting might be a financial consideration as nursing homes may not seek out an MSW with a clinical level of expertise, or value it enough to attract or retain this level of professional social worker.

A high percentage of social workers in both rural and metropolitan nursing homes do not have professional social work supervision. The concept of "grieve out" brings together the stressors of caregivers of the dying and the lack of emotional disengagement in a routine manner via professional supervision to identify past grief issues and

transference in maintaining professional job competency and mental health. This "...withdrawal of emotional investment in the lost person." (Bowlby p.25.) and Dick Obershaw's concept of "grieve out." are not dissimilar but validate the attachment the social worker has in this therapeutic relationship on the health care team. Since these concepts are not dissimilar, but rather descriptors of the process this researcher was seeking to establish data that validate the phenomena of "grieve out." This research design was not comprehensive in that it might assist in determination of why social workers in nursing homes do not pursue greater formal education or recognize professional supervision as a distinct entity. There is a profound difference between a meeting with supervisory personnel with no clinical merit, and a discussion of transference and clinical follow-up of depression in nursing home residents by the on-site social worker. In the future it may be that the nursing home's MSW is able to bill for services such as these maintaining continuity and cost efficiency for both the patient and the nursing home by having this service at the nursing home.

The purpose of this thesis was to explore the concept of "grieve out" as defined by Obershaw as the "...emotional investment ...staff invests and never divest of the relationship" upon the death of the resident. Doka's theories of disenfranchised grief, and Bowlby's attachment and loss theories and Vachon's occupational stress theories assist in defining the internal process of grieving that the nursing home social worker is experiencing each time a resident dies. The graphic image of "grieve out" illustrates a finality one who is "burned out" with their grief as they are unable to regularly or sufficiently process these multiple losses. Emphasis must be placed on this condition as a

process with the end point being the termination of work by the worker. In a phone interview with Dick Obershaw this researcher was given general descriptions of health care personnels who had insufficiently debriefed these losses in the work environment. The result is seeking counsel from friends and family such that their spouses were given too great a role in sharing their grief process and the home relationship was in jeopardy. (D. Obershaw, personal communication, October 1994 through February 1995). Vachon suggests education, training , and importance of personal philosophy and coping strategies for processing grief especially as a member of a team and seeking support within that environment. The data from this study notes that nursing home social workers are not required to have professional training in the area of grief and death for hire nor was their training offered at work, and indeed some rural nursing home social workers were unaware of local agencies to provide this service. It was felt from this data social workers are in a unique position to assist with the grief of the care team and through this are able to identify their own grief through professional supervision.

Vachon suggests that educational forums need to be orchestrated to meet the needs of the participants. The results herein reveal physiological signs of grief as well as respondents requests for greater educational programming, an education they are experiencing signs of "burnout". Since these social workers are unable to equate themselves as disenfranchised grievers and access appropriate supervision, it is probable they are at risk for "grieve out". One recommendation would be availability of grief forums from agencies such as the Minnesota Department of Health, the National Association of Social Workers, or the Minnesota Nursing Home Social Workers

Association, to name a few.

In conclusion, social workers in this exploratory study of issues surrounding death and grief, exhibited signs of stress, and a need for greater professional supervision. In this way they have a potential for "grieve out." They are, however, open to training on these issues of grief and dying. Frequency of training was not addressed by this tool. Respondents were also open to opportunities that arise in their environments that are supportive and contribute to their personal coping skills. Both rural and Metropolitan social workers identified physiological symptoms that suggested grief, overtime work, and a lack of regular professional supervision, examples of the need for boundary definition. This tool did not delve into the social worker's personal life or what would be considered external factors of stress. It is the hope of this researcher that future studies will follow-up with other care givers, and assess issues in greater depth, in the nursing home setting in hopes that better training requirements and mental health services be not necessarily mandated, but at least available. Greater efforts might then be identified and valued by policy analysts to ensure these services are available locally to all those who are bereaved. As the population at this time is aging and there will be a surge in the numbers of services to the elderly as the "baby boomers" age, this study has sufficient reliability for future studies.

APPENDICES

APPENDIX: A

GLOSSARY

Burnout: Defined by Freudenberger, H.J. & Richelson, G. (1980) "To deplete oneself, To exhaust one's physical and mental resources. To wear oneself out by excessively striving to reach some unrealistic expectation imposed by one-self or by the values of society."(p.16). Those he defines as most susceptible are"...the dedicated and committed" (p.19)

"Grieve Out" defined by Dick Obershaw(a therapist from Burnsville) as "emotional investment...staff invest and never divest of the relationship" upon death of the resident.

Metropolitan counties: Anoka, Dakota, Hennepin, Ramsey, Scott, and Washington.

Nursing home is to be defined as a twenty-four-hour skilled care facility to meet the basic needs of elderly persons who no longer are able to remain at their homes.

Rural counties include: Aitkin, Beltrami, Big Stone, Cass, Clearwater, Chippewa, Chisago, Crow Wing, Faribault, Filmore, Freeborn, Grant, Goodhue, Houston, Itaska, Jackson, Kanabec, Kandiyohi, Lake, Le Suer, Lyon, Martin, McLead, Mille Lacs, Morrison, Nickollet, Nobles, Norman, Olmstead, Ottertail, Pipestone, Polk, Pope, Red Wood, Renville, Rock, Sterns, Scott, St. Louis, Steele, Todd, Winona, Wright, Yellow Medicine.

Social work designee: in the context of a nursing home, as that person responsible for case management services, psychosocial assessments, social histories and admission or discharge appropriateness. No social work license.

APPENDIX B

Letter and Consent Form

(Researcher's address)
March 1995

Director of Social Services

Dear Colleague:

You are invited to be in a research study regarding issues surrounding death and grief. You were selected as a possible participant by random selection from a master list provided by the Minnesota Department of Health. This study is being conducted by Gena du Bois in partial completion of the degree requirements for the Masters of Social Work at Augsburg College in Minneapolis, Minnesota. This research will consist of responses to a questionnaire that should take an estimated 15 minutes to complete. If you are the Director of Services I request that you pass this letter and questionnaire on to a social worker. Please convey to the social worker that participation is voluntary.

Before agreeing to be in the study, please read this form and contact me at the number below for answers to any questions you may have. If for any reason you desire to skip a question or end participation you may do so at any time. No one at your nursing home will be aware of your participation nor will they have access to any of the individual responses in the study. All information will be kept in a locked file to which only the researcher will have access. All contact from this researcher will be by mail.

This is an exploratory study to survey those individuals in social work or social work designee positions who deal with the death of residents and the resulting closure issues. The purpose of the research is to establish a baseline of current knowledge of social workers in nursing homes. This study has been reviewed and approved by the Augsburg College's Institutional Review Board (IRB).

Your decision to participate will not affect any future relationship with Augsburg College. There are no monetary benefits for participation in this study.

If you agree to be in this study, please do the following: complete and return the questionnaire in the enclosed self-addressed stamped envelope by March 30. Completion of this questionnaire implies consent to participate.

Thank you for your interest and willingness to participate in this research. You may call with any questions you have. The researcher for this study is Gena du Bois to be reached at (612) 681-8407. The thesis advisor is Mary Lou Williams (612) 330-1157.

Sincerely,
Gena duBois LSW

APPENDIX C

Questionnaire: Please answer the following questions.

1. Gender: a. Male __ b. Female__
2. Training:
   a. BSW__ b. RN___ c. Other (Please explain)._____.
   d. MSW___ e. LPN___
3. This nursing home is:
   a. Non profit___ b. For Profit___ c. Church affiliated__
4. Job title:_____.

5. The total number of years in this position:____
   a. 1 year or less___ b. 2-3years___ c. 4-5years___
   d. 6-10 years___ e. 11-20 years___ f. over 20 years___

   The total number of years experience in social work positions.
   a. 1 year or less___ b. 2-3years___ c. 4-5years___
   d. 6-10 years___ e. 11-20 years___ f. over 20 years___

6. On a scale from one to five rate your level satisfaction with the job prior to acceptance of this position:
   Satisfied 1 2 3 4 5 Dissatisfied

7. Professional supervision is provided by:
   a. A social worker with a/an: BSW___MSW___LCSW/LICSW__
   b. A nurse___
   c. An administrator___
   d. Other:_____professional discipline_____

   If **not** do you pay for this:
   a. Yes__ b. No__ c. Not applicable___ d. Other_____

8. Frequency of professional supervision:
   a. Weekly___ b. Monthly__ c. Yearly___d. I do not have supervision___
   e. Twice a month___ f. Quarterly__ g. As needed___

9. Do you feel that as a result of supervision you are better equipped to perform your job?
   a. Yes___ b. No___ c. Not applicable___ d. Other___

10. Are you ever required to perform tours or the admissions process?
    a. All the time__b. Sometimes___c. Only when admissions staff are absent__
    d. Other___
11. What percentage of your time is spent on tours or admissions?
    a. 0__ b. 1-25%___ c. 26-50%___ d. 51-75%___ e. 76-100%___
12. Do you feel emotionally attached to residents?
    a. Always___ b. Frequently__ c. Sometimes___ e. Rarely__ d. Never___

13. Upon death of the client which of the following have you experienced?
    a. Headache__ b. Relief__ c. Reluctance to see clients__
    d. Fatigue___ e. Agitation__ f. Lack of appetite___
    g. Stomach problems___h. Tardiness__ i. More use of alcohol or drugs___
    j. Poor concentration___k. Problems sleeping__ L. Other_____

14. Did you experience a change in the intensity of these feelings in the last month?
    a. Yes__ b. No__

15. Rate the frequency of family visits during the most recent death of a resident.
    Daily visits 1 2 3 4 5 No family visits

16. During the most recent progressive extended death at the nursing home, how would you rate the family involvement. (Rate from one to five).
    Supportive 1 2 3 4 5 Unable to cope
    Other_____

17. Were you able to complete closure?
    a. Yes__ b. Anticipatory grieving occurred as it was a long death___
    c. No___ d. Other_____

18. Was this a factor in your grieving process?
    a. Yes__ b. No__ c. Other_____

19. Were you able to make closure with the family?
    a. Yes__ b. No__ c. Somewhat__ d. There was no family___

20. Do you assist families in removing residents belongings after they die?
    a. Always___ b. Frequently__c. Sometimes___ d. Rarely__ e. Never___

21. Are deaths more difficult to accept when you are not able to have closure with the family or if there is no family?
    a. Always__ b. Frequently__ c. Sometimes__ d. Never__ e. Rarely__

22. Are deaths more difficult to accept when you are not able to have closure with the resident?
    a. Always__ b. Frequently__ c. Sometimes__ d. Never__ e. Rarely__

23. Do you have a hospice program or utilize their philosophy in your nursing home?
    a. Always__ b. Frequently__ c. Sometimes__ d. Never__ e. Rarely___
    f. Other_____

24. Are you or members of the social services department expected to assist with staff grief issues?
a. Yes__ b. No__ c. Indirectly__

25. On a scale from one to five what is your comfort level with assisting staff with bereavement?
Very comfortable 1 2 3 4 5 Uncomfortable

26. Which of these concepts do you utilize at your facility when a resident is dying?
a. Pain management__ b. Non aggressive treatment__ c. Volunteers__
d. Sensory stimulation___ e. Staff diary for the bereaved___f. Pastoral care__
g. Allow family vigils___ i. Notify staff for the purpose of closure___
h.Other_____

27. Is there a chaplain at the nursing home?
a. Yes ___
b. No___
c. Local churches come in to minister to residents and families as requested____

28. Funerals/memorial services are held at the nursing home:
a. Monthly___b. As requested by family___ c. As requested by the Resident___
d. Yearly__ e. As requested by staff____ f. Other_____

29. When you experience grief related to the death of a resident, which of the following supports do you use.
a. A social worker____ b. The nursing home chaplain___ c. NAR___
d. The charge nurse___e. None are available___ f. Other_____

30. Check as many of the following terms that describe how you feel at this time:
a. Unmotivated___ b. Loss of energy___ c. Change in Concentration__
d. Change in sleeping patterns___ e. Reluctance to come to work___
f. Frequent head aches__g. Guilt about the job_ h. Feeling like a failure__

31. Do you take regular vacations?
a. Yes__ b. No__ c. Sometimes__
How often?
a. Monthly___ b. Yearly___ c. Other_____

32. Describe how you take your vacations? (check all that apply)
a. Several days at a time___ b. Weeks at a time___c. Just around holidays___
f. As needed for child care___e. Rarely___ f. Other_____

33. When you go on a vacation do you bring work home?
a. Yes___ b. No___ c. Sometimes___

34. While on vacation do you receive business calls at home?
a. Often___ b. Occasionally___ c. Never__ d. Other_____

35. Do you regularly work more than 40 hours each week?
a Never__ b. 25 % of the time___ c. 50 % of the time___ d. 75 % of the time___
e. 100%___

36. Do you feel the administrator understands the process of grief and encourages education for staff on this issue?
a. Yes___ b. No___

37. Did you receive training prior to employment at the nursing home in the area of death, dying and grief?
a. BSW/MSW curricula____ b. Seminars__ c. In services___d. Other_____

38. Did the nursing home offer death and grief training as a part of your orientation?
a. Yes____ b. At a later date not during training, but at an in service____
c. No____ d. Other_____

39. If you recieved grief training prior to this position, was this training a requirement for your position?
a. Yes____ b. No____

40. Do you feel you had adequate training to deal with the dying process ?
a. Yes__ b. I recieved some training that was insufficient___
c. No___ d. Other_____

41. During stressful times is your supervisor available to provide professional support?
a. Yes___ b. No___

42. Does your employer offer mental health services such as an employee assistance program for you and other staff members under their benefits program?
a. Yes___ b. No___ c. There are no health benefits.___
d. Benefits do not include these services.____

43. Are these services readily available in the community if your employer were to offer them?
a. Yes____ b. No____ c. Unknown____ d. Not applicable___

44. Would you like to see training workshops offered on death and bereavement?
a. Yes___ b. No___ c. Comments:_____

45. On a scale from one to five rate your level of job satisfaction at this time.
Satisfied 1 2 3 4 5 Dissatisfied

Thank you for participating.

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