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The Experience and Coping of Hospital Social Workers with Critical Incidents

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THE EXPERIENCE AND COPING OF HOSPITAL SOCIAL WORKERS WITH CRITICAL INCIDENTS

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DEDICATION

I dedicate this thesis to my family and friends who made it possible for me to pursue my graduate studies and who gave me the ability and strength to cope through stressful times and experiences. I am forever grateful and I love you all.

* Bryon, thank you for your unending love, patience, support and confidence in me – you believed when I did not. Thank you also for being both "mom" and "dad" during this journey. Your strength, love, and steadfastness kept our home a warm, safe and welcoming place to be. I am truly blessed to have you for my husband.

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ABSTRACT

THE EXPERIENCE AND COPING OF HOSPITAL SOCIAL WORKERS WITH CRITICAL INCIDENTS

A QUALITATIVE STUDY

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The purpose of this qualitative study is to gain a deeper understanding of the lived experiences of seven hospital social workers surrounding stress and coping with critical incident experiences. Participants were gathered through a non-probability sample and identified by a key informant in the field of hospital social work. Research was conducted through an in-depth interview where participants were asked to describe personal critical incident experiences and methods used to cope with stress. Results found that situations involving life and death, personal connections and politics of the environment were most often viewed as critical incidents. Furthermore, these experiences were best coped with through support of peers, balance in life, education and a personal fit to role. Finally, it was found that experiences not only impacted participants by creating emotional reactions, but also served as a means for personal and professional growth. Implications for social work practice and policy are discussed.

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CHAPTER 1: INTRODUCTION

Background of Problem

The field of social work is known for attracting individuals who are people oriented, empathetic, and sensitive towards others (Acker, 1999). In addition, for many, the desire to enter the profession of social work is accompanied by a desire to show care and compassion for others. Compassion, as described by Lamendola (1996), is not pity; rather, it is the recognition of another person's suffering and a commitment to help regardless of the outcome. "Compassion is a virtue that takes seriously the reality of other persons, their inner lives, emotions as well as external circumstances. It is an active disposition...toward supportive companionship in distress or in woe" (Murray, 1996, p.7). All the same, while compassion and a desire to help others may lead a person to the profession of social work, the continual responsibility to meet the emotional and physical needs of clients, along with routine, direct contact with high needs people can place a stress on social workers (Acker, 1999). Social workers, being in a profession among one of the "helping professions," are vulnerable to developing stress reactions due to the emotional burden of working with distressed clients (Cwikel et al., 1993; Sze et al., 1986). Likewise, this vulnerability increases, as well, based on the setting and role such as when the social worker is in a health or hospital setting (Dillon, 1990; Sze et al., 1986). A health or hospital social worker's position is described as needing to be adaptable to switching roles, functions and status from moment to moment (Dillon, 1990). Further adding to the stress of the hospital social worker role is the distress of the clients. A

hospital social worker's clients can include patients facing mental illness, terminal illness, as well as people facing critical incidents or traumatic experiences. Because of the stressful nature of social work and the increase in stress when in a hospital setting, there is a risk of emotional reactions and dissatisfaction in the job.

Over the last couple of decades interest has been given to the level of job satisfaction among social workers (Acker, 1999). Similarly, attention has been given to the role and satisfaction of hospital social workers. This attention to the profession of social work has found that while all social workers, regardless of setting, face emotional reactions, hospital social workers in particular face emotional reactions to their stressful setting. Working in a hospital setting where a social worker is providing service to patients who may be mentally ill, critically and or terminally ill contributes to the experiencing of routine stress and can lead to significant physical and emotional reactions, known as critical incident stress (CIS) (Cwikel et al., 1993; Lewis, 1993; Mitchell, 1983). In turn, CIS can lead to emotional, physical, and mental exhaustion, historically referred to as burnout and more recently as a new phenomenon called compassion fatigue. Burnout, in turn, has been found to cause low morale, low productivity and also emotional withdrawal. Furthermore, left unattended, burnout and compassion fatigue have been found to lead to posttraumatic stress disorder (PTSD) (Schwam, 1998; Tout et al., 1990). In spite of the stressful nature of hospital social work and the outcomes that may occur due to exposure of routine stress or critical incidents, not all hospital social workers succumb to burnout and compassion fatigue; rather,

some adopt techniques and strategies to help cope with the stress of hospital social work and critical incidents (Dillon, 1990).

Statement of the Problem

This research study addresses the question of what it is like for hospital social workers to experience critical incidents and how critical incident stress is managed in their lives. The purpose and significance of the research study is to describe the lived experience of hospital social workers in order to understand the effects of critical incident stress as well as what coping techniques and strategies are used to avoid burnout and compassion fatigue. While researching the area of critical incidents and critical incident stress, many theories are found addressing responses to stress as well as coping methods. These theories will be explored while addressing the lived experiences of hospital social workers, their experienced critical incidents, critical incident stress, and methods used to cope with CIS. Furthermore, how the experiences, if at all, have impacted the lives of the social workers will be explored.

Research Question

Specifically, this research study will ask: what is the lived experience of hospital social workers relating to critical incident stress? And, how do hospital social workers cope with the impact of stressful events? The actual questions asked of participants are included in Appendix C.

Summary

While many social workers entered the profession as a result of their compassion and a desire to care for others, hospital social workers may work in

atmospheres where critical incidents may be routinely experienced and occupational stress is high. These experiences and critical incident stress have been known to lead to job burnout, compassion fatigue and also posttraumatic stress disorder. Yet not all hospital social workers give in to these reactions; in their place, strategies and coping techniques are put into practice to overcome the occupational stress experienced.

This chapter addressed the background of the problem of hospital social workers experiencing critical incidents and the stress involved with hospital social work. The following chapter will discuss the literature surrounding the stress of social work with specific attention to hospital social work. Chapter three will present the theoretical framework of stress and coping. Methodology used for this study will be presented in chapter four. Chapter five will present findings of the study and in conclusion, chapter six discusses areas of limitations and implications for further studies.

CHAPTER 2: LITERATURE REVIEW

Introduction

In this literature review, terms used within the literature surrounding stress and coping will be defined. Next, occupational stress of the social work profession, specifically experienced by hospital social workers, will be explored. Physical, mental, emotional and occupational effects of this stress on social workers will similarly be explored. Subsequently, a framework is provided to address the concepts of critical incidents, critical incident stress (CIS) and responses to stress including burnout, compassion fatigue and posttraumatic stress disorder. Conclusively, coping techniques and strategies used by social workers to withstand occupational stress and critical incident stress will be discussed.

Definitions of Terms

For the purpose of this study, the following terms are operationally defined:

Burnout: the syndrome of emotional, physical and mental exhaustion, including a reduced sense of personal accomplishment, an indifference to clients and a negative attitude of the job (Cwikel et al., 1993; Goldberg et al., 1996; Kennedy et al., 1997; Spitzer et al., 1992; Tout et al., 1990).

Hospital Social Worker: a licensed social worker with work experience in a hospital setting including medical floors, hospice, mental health units and the emergency department.

Critical Incident (CI): any situation or experience that causes overwhelming dramatic emotional reactions, which have the potential to interfere with the ability to function normally (Mitchell, 1983; Spitzer & Burke, 1993).

Critical Incident Stress (CIS): a set of physical, cognitive and/or emotional reactions or symptoms that occur due to a critical incident, and impairs the ability to cope. These reactions and symptoms may occur immediately upon a CI or may be delayed days, weeks or even months (Lewis, 1993; Mitchell, 1983).

Compassion Fatigue: the emotional burden experienced as a result of overexposure to critical incidents and patients of traumatic, critical events (Schwam, 1998).

Coping: a person's cognitive and behavioral change made in attempts to manage external and internal conflicts and stressors (Folkman et al., 1986).

Occupational Stress of Hospital Social Work

While many occupations today are familiar with high levels of stress, there is substantial evidence that social work, specifically hospital social work, is of one of the most highly stressful occupations (Dillon, 1990; Sze et al., 1986). The hospital social worker is described as having to be "constantly moving on a moment's notice between potentially conflicting roles, statuses, functions and contexts" (Dillon, 1990, p. 91). Further, hospital social workers must work under conditions of "unknown" as each day and each client brings new and uncontrollable variables. Hospital social workers have "little control over whom they see, the nature and length of contacts with clients, the shape of the workday, the range of expert functions they will be requested to carry out, the value placed

by others on their work, or even the physical space delegated to them" (Dillon, 1990, p. 93). Furthermore, in addition to the stress of their ever-changing role, hospital social workers are faced with working in a "host setting" that is often unclear of their place and purpose within the hospital and therefore, hospital social workers are often misunderstood by their professional colleagues (Acker, 1999; Keigher, 1997). Hospital social workers also face a host setting where they can feel like the outsider due to the specialized "foreign" language of the medical terminology. Likewise, social workers face the conflict of operating and advocating client empowerment and self-determination in a setting that expects patient compliance (Dillon, 1990; Keigher, 1997; Netting & Williams, 1996).

A review of the literature identifies primary sources of hospital social work stress to include an overload of work due to high patient volume, feelings of inadequacy, low level of remuneration, interpersonal conflicts, constantly changing work environment, job dissatisfaction, and a lack of or poor communication, understanding, and support of the host setting (Cwikel et al., 1993; Sze et al., 1986). While these areas of stress revolve primarily around personal and environmental work factors, working directly with patients creates even more stressors.

Hospital social work involves an emotional connection to people who are experiencing physical and/or mental distress. Routinely hospital social workers are confronted with patients experiencing hunger, violence, exploitation, poverty, illness and trauma (Dillon, 1990). Additionally, hospital social workers often serve "unpopular patients" such as those with AIDS, homelessness, patients with

less resources, and elderly. These patients are considered unpopular and receive the label of negative health consumers based on the deficits they raise in a system focused on profit. In addition to these stressful relationships with patients, the social workers connection to patients can even lead to stress through experiences of death and separation of the patient (Dillon, 1990; Sze et al., 1986). Likewise, experiences with death can lead to greater stress as the social worker may begin to acknowledge mortality not only with their patients but in their own lives as well. In addition to emotional ties to patients, ethics often come into play when social workers struggle with their ideas of types and length of care they believe the patient should be receiving as compared to care being prescribed by the medical institution. This not only brings up ethical concerns but a concern over a lack of control and decision-making ability as well. "Workers will be under increasing pressure to hurry clients out of care, to act 'in denial' of ongoing unmet needs, to look away from questionable management behaviors" (Dillon, 1990, p. 100-101).

Experiencing stress can push a person to become creative, efficient and effective. Yet, while some stress in daily life is considered healthy, if prolonged or excessive, stress can lead to an inability to adapt and dysfunctional coping may occur (Heuer et al., 1996; Spitzer & Neely, 1992).

Effects of Occupational Stress of Hospital Social Workers

Routine exposure to working with patients facing extreme life stressors themselves, place hospital social workers in a position of experiencing occupational stress. When occupational stress becomes too excessive or lasts too long there is substantial evidence that disruptions may occur psychologically as

well as physically. Emotional exhaustion, bouts of flu, headaches, low self esteem and substance abuse, to name only a few, may occur (Acker, 1999). This stress may also lead to impairments with professional practice including, but not limited to, low or impaired performance, low morale, high absenteeism and turnover and also a blaming of the client (Acker, 1999; Spitzer & Neely, 1992). Hospital social workers, affected by occupational stress, may become cynical and blaming of their patients. Likewise, they may lose their dedication towards their work with distressed patients and become ineffective or even careless in their job.

It is suggested that stress is linked to disease and illnesses, including coronary heart disease, some types of cancer, mental illnesses and health-compromising behaviors including smoking, poor diet and exercise and substance abuse (Acker, 1999; Norrie, 1995; Quine, 1998). Additionally, excessive stress can affect both personal and professional areas of an individual's life. On a personal level, stress may lead to feelings of inadequacy, hopelessness and failure. These feelings in turn may not only affect the social worker's self-view of their professional ability, but personal esteem may be affected as well. Therefore, life outside of the workplace can become affected including a stressful family life and a lack of positive social life. Moreover, these feelings of inadequacy, hopelessness and failure may be acknowledged openly or left unacknowledged. They may also be acted out through dysfunctional behaviors (Heuer et al., 1996). Professionally, stress may lead to job dissatisfaction, absence from work, poor performance, unsafe behavior, accidents, and leaving the profession all together (Acker, 1999; Spitzer & Neely, 1992).

Critical Incident/Critical Incident Stress

Over the last decade the concepts of critical incident and critical incident stress (CIS), first used by psychologist Jeffrey Mitchell, have developed and have been the subject of several research studies (Lewis, 1993; Mitchell, 1983; Werner et al., 1992). While historically, the studies and terms have been used primarily in connection with emergency service personnel, such as police, firefighters and rescuers, recently it has been acknowledged that occupational stress related to critical incidents and CIS can exist in any environment where there are life threatening situations and/or routine exposure to highly stressful events. Any situation that involves the care and service delivery to people involved with crisis and traumatic experiences can include critical incidents and therefore, CIS may occur (Spitzer & Burke, 1993; Spitzer & Neely, 1992).

Critical incidents and CIS, as written about within the literature, have historically and most often been associated with major disasters and catastrophic events, however, a situation does not need to meet this magnitude to be considered a critical incident. Any situation, which provokes overwhelming feelings of emotion, may be defined as a critical incident and can lead to critical incident stress (Lewis, 1993; Mitchell, 1983; Spitzer & Neely, 1992).

Critical incident stress may develop from a single incident or from a number of incidents compiled and may be experienced immediately or take days, weeks, or months to develop (Mitchell, 1983). Symptoms and reactions associated with CIS include cognitive impairments such as memory loss, impaired decision-making capacity, and loss of attention span. Emotional symptoms can

include anger, frustration, irritability, guilt, fear, paranoia, and sadness or depression. Physical symptoms may include dizziness, headaches and fatigue. Other reactions may include self-destructive behaviors as well as isolation. Due to the significant cognitive, emotional, and physical effects of CIS on health care providers, Spitzer & Neely, (1992) note the danger to patients and families who rely on health care providers' competent and safe care, as the effects of CIS may jeopardize this care.

Stress Response Syndromes

The cognitive, physical, emotional and behavior reactions and symptoms which occur following a critical incident or stressful situation are considered normal in every way and are often viewed as defense mechanism of the mind and body for survival (Mitchell, 1983). While these reactions are considered normal, left unacknowledged and unattended these reactions and symptoms can become destructive and lead to serious illnesses (Werner et al., 1992). Occupational burnout, compassion fatigue and posttraumatic stress disorder are some of the problems cited within the literature that may occur if the reactions and symptoms of CIS are left to linger.

Burnout

The term "burnout" was first used in 1974 by Freudenberger to describe the condition of physical and emotional exhaustion due to stressful conditions at work (Iacovides et al., 1997). These stressful conditions may range from various shift changes at work, high patient volumes, limited resources, lack of decision making ability, feelings of inadequacy, interpersonal and professional conflicts

and exposure to critical incidents related to caring for mentally ill, critically ill or dying patients. Furthermore, these conditions are said to lead to depersonalization and low sense of personal achievement along with physical and emotional exhaustion (Goldberg et al., 1996; Perkin et al., 1997; Sze et al., 1986).

Burnout begins with emotional exhaustion, feeling tired from work with no mental strength to reinvest in work. Next, isolation may occur in order to defend one's self from the affects of the exhaustion. In this stage, impersonal relationships begin to occur with patients. This will lead to a decrease in performance of work, which is considered the final stage of burnout (Iacovides et al., 1997).

Burnout has been linked to inner personal conflicts including substance abuse, marital discord, poor mental health, absenteeism, and on the job injuries (Acker, 1999; Goldberg et al., 1996). Burnout has also been said to cause hospital social workers to become indifferent and cynical of clients (Cwikel et al., 1993, Sze et al., 1986). In addition to the problems acquainted with the person suffering from burnout, organizations suffer as well, and experience conflicts from the burnout. High turnover, low job satisfaction and a decrease in the quality of care given to patients have been attributed to personnel burnout (Perkin et al., 1997; Sze et al., 1986).

Historically, stress and burnout within the health care system has primarily focused on first response personnel and emergency services, however, more recent studies have shown that any health care providers may suffer and experience stress and burnout. Role and location are no longer the sole

contributing factor, rather, critical and stressful incidents experienced are acknowledged as the causes for burnout and it is also acknowledged that an incident considered non-stressful to one person may be extremely stressful to another individual (Dugan et al., 1996; Spitzer et al., 1992).

Compassion Fatigue

The concept of burnout, specifically burnout in social work, has been of interest over the past few years and therefore is not a new idea. Compassion fatigue, on the other hand, is a relatively new concept and phenomenon. While burnout and compassion fatigue are often referred to as similar phenomenons due to their similar qualities, this is a misconception as they are not the same (Schwam, 1998). Burnout is connected to the everyday stressors and hassles of a workplace. Compassion fatigue, in contrast, is associated with intense, prolonged exposure to traumatic, critical situations. Over time, caring for patients involved with traumatic and critical situations, along with the witnessing of human misery, can cause an emotional burden for hospital social workers (Schwam, 1998). Social workers can become physically and emotionally overloaded and develop symptoms and reactions to their experiences. These symptoms may include numbed feelings, fear, isolation, nightmares and addictive or compulsive behaviors. Additionally, feelings of grief, anxiety, rage and shame may be experienced (Clark & Gioro, 1998; Sze et al., 1986). These intense, psychological symptoms, occurring due to prolonged exposure to critical stress and witnessing of suffering, have led some researchers to link compassion fatigue with posttraumatic stress disorder (Marmar et al., 1996; Schwam, 1998).

Posttraumatic Stress Disorder

Posttraumatic stress disorder (PTSD) has traditionally been associated with war and armed combat. Presently, however, PTSD is considered to be the result of not only war experiences but also factors outside of war that involve exposure to traumatic situations and critical incidents (Lewis, 1993; Schwam, 1998). Furthermore, Schwam, (1998) describes PTSD as the "re-experience of anguish and fear" and continues by acknowledging that individuals outside of war and combat experiencing stressful situations have also been found to have psychological reactions and symptoms that compare to symptoms of PTSD.

Symptoms and determinants of PTSD, which may be seen as similar to those of CIS, include: exposure to extraordinary stressors which provoke overwhelming emotions, re-experiencing an aspect of the trauma, avoiding anything related to the trauma and/or external environment, and physical symptoms including: hyper arousal, intrusive images, irritability, insomnia, temper and anger (Lewis, 1993; Schwam, 1998).

Techniques and Strategies of Coping

While the social work profession is considered to be stressful by nature and hospital social workers experience routine and daily stress, not all social workers experience CIS or the stress response syndromes, rather; some social workers are able to cope with the stress. Coping techniques and strategies have recently become popular topics in literature. Coping methods have been categorized in four areas. First is the "ego defensive strategy" which observes stressful situations as being denied or repressed. Used long term, this strategy

may cause lasting personality changes. Second, the "personality trait" stresses the characteristics of a personality that allows one to cope naturally. Next, "situation grounded coping" involves changing the situation while ignoring differences in individuals. Finally, "phenomenological/transactional coping" emphasizes the individual and suggests the person will adapt to the stressful situation (Norrie, 1995). Variations in these four categories are found throughout the literature.

The most written-about method within the literature on coping is the Critical Incident Stress Debriefing (CISD) as designed by psychologist Jeffrey Mitchell. In addition to debriefing, a grief workshop, counseling variations and education plans aimed at aiding in coping strategies are found. Finally, the ability to cope based on personality traits and individual's beliefs and behaviors are also topics of recent studies

Critical Incident Stress Debriefing

The Critical Incident Stress Debriefing (CISD) process was first developed by Jeffrey Mitchell to help emergency response workers cope with experienced critical incidents and to prevent long term effects or stress response syndromes (Sowney, 1996). CISD includes four types of debriefings. First, the "On-Scene or Near-Scene" is brief and includes a facilitator checking in on the well-being of workers, as well as suggesting when workers may need to take a break during an incident. While on a break, support and listening to a worker is also a role of the facilitator. The second type or the "Initial Defusing" is to occur within hours of the incident. In this debriefing it is not specified who is the leader, instead the importance is for the workers to have an opportunity to express

themselves in a positive and supportive atmosphere with genuine concern and understanding. The third debriefing is called the "Formal CISD." The formal CISD is led by a qualified mental health practitioner 24 to 48 hours after an incident and includes six phases. The "introductory phase" sets the tone and the rules for the debriefing including confidentiality discussions. The "fact phase" involves participants introducing themselves, followed by a narration of the incident and their involvement in it. The "feeling phase" probes how the workers felt during the incident, how they feel currently and if they have ever experienced this feeling prior to the incident. The "symptom phase" addresses unusual experiences for the workers during and after the incident. In this phase, stress responses are explored and identified. The "teaching phase" is used to educate the workers about the stress responses including signs, symptoms, and emotional reactions. In this phase workers learn that their reactions are normal while they may be feeling abnormal. The final phase, "re-entry" is used to answer questions and help workers find a direction or activity to move towards. The fourth type of debriefing is called the "Follow-up CISD" and occurs weeks or months after an incident. The follow-up is necessary only when an issue or problem has developed, due to a critical incident, and further help is needed (Mitchell, 1983).

While CISD was developed to work with emergency service workers it has since been implemented in hospital settings to aid hospital employees who have experienced critical incidents. Many benefits of debriefing have been stated within the literature involving CISD and hospital employees. Debriefing can prevent and put an end to rumors by providing information and facts where once

only hearsay was known. Additionally, through education on reactions to stress an individual may feel empowered, rather than abnormal, due to the reactions they are experiencing. Hospital organizations will also benefit, as a therapeutic, supportive climate will be produced, encouraging open discussions. A reduction of stress was also found in hospital employees who participated in CISD (Blacklock, 1998).

Along with benefits, criticisms also occur. Some hospital employees stated that the atmosphere was not favorable for expressing honest feelings as some hospital employees have been trained not to express their feelings in fear of appearing weak or unable to handle the job. Others indicated a problem with time. Some felt the debriefings occurred too soon after an incident, while others felt there was not enough time to discuss the incident just after it occurred (Blacklock, 1998; Sowney, 1996). Despite these criticisms, it is agreed that some form of debriefing, whether it is CISD or another type of coping management tool, is needed in the hospital settings in order to aid hospital employees with experiences of critical incidents and stress.

Variations in Counseling and Education

One form of stress that may be experienced by hospital social workers is the grief felt over the loss of patients (Dillon, 1990). Grief left unacknowledged can lead to stress responses, yet when these feelings are acknowledged and facilitated they can help a hospital social worker to invest in new relationships and become more effective in their role as advocate and care giver (Hinds et al., 1994). Some facilities provide support services to help with grief. This support

may come in the form of memorial services, education on grief and loss, and support groups including peer support groups (Hinds et al., 1994; Hine, 1996).

In a research project, Hinds et al. (1994) developed a one time, three hour grief workshop with the objectives of: providing information about grief, disenfranchised grief and the grieving process; and to describe self-care activities that help the grieving process. In the study, Hinds et al. (1994) found that a single workshop did not offer enough intervention and support to significantly reduce the symptoms of stress, instead, they suggest a series of planned workshops be implemented due to the need for time in the grieving process. However, they did find that the participants experienced positive changes in feelings about themselves and their place in the group that were beneficial in the single workshop. Along with the benefits found, Hinds et al. (1994) stress the need for an intervention of some type in order to facilitate the grieving process.

Similar to the support needed for grief, support for stress in general is also needed in hospital settings to help facilitate coping. These supports may come in the form of educational programs, free, confidential counseling services, critical incident stress management, and/or assistance with staff problems and evaluations (Turner, 1997). Training in coping skills and time management to help hospital social workers deal with work stress more efficiency are additional areas to explore for supports (Boey, 1998; Sze et al., 1986).

Fursland (1987) exploring nursing stress suggested four areas where hospitals can facilitate coping, which also is applicable to hospital social workers. The first area is "knowledge" as an important factor in coping. Knowledge may

come in educational programs or study days with opportunities to discuss patient's issues as well as ethical issues. The second area for coping is "support." Support may be formal or informal and come on many levels. To begin, there need to be enough staff on a shift in order to support each other and to fulfill job requirements. Mentoring is another form of support where senior employees help junior staff when needed. Group discussions, similar to debriefing, yet less formal, may also help support hospital social workers. And finally, informal support comes through a shown genuine concern for each other through being available when a co-worker is in need. The third area to facilitate coping with stressful experiences is by "creating a positive atmosphere" including hope, humor and cohesiveness. This positive atmosphere is beneficial not only to the employee, but to the patients as well. Finally, "patient allocation" is a form of facilitating coping. Patient allocation allows a patient to be assigned to a different social worker when the current social worker is in need of a change. This also may mean re-assignment of a social worker to a new work area for a change altogether (Fursland, 1987).

Personality and Coping

Personality and coping has been a popular concept in literature. When addressing personality factors that help resist stress, a distinction must first be made between personal and social factors. Social factors are resources that may be used during stressful times. These may include social networks such as family, friends and co-workers. Personal factors, in contrast, include characteristics and acquired coping strategies that can be used from within a person when stressful

situations occur. Personal characteristics have been said to include the following: hardiness, self-esteem, internal locus of control, and Type B behavior pattern (Boey, 1998).

The hardiness concept claims that some people are simply more able to handle high levels of stress and remain healthy while other, non-hardy people will become ill when confronted with stressful situations. Hardy people are believed to contain three characteristics: a belief that one can control the occurrences of positive and negative events; a commitment to tasks and people; and a belief that a challenge is opportunity for growth (Boey, 1998). While a great deal of interest and research was given to the concept of hardiness, many limitations were found, and other explanations were often found to explain the management and coping of stress.

Self-esteem as a characteristic to aid in coping is seen as the combination of self-confidence and self-efficacy. Furthermore, self-esteem has been found to serve as a barrier between stress and negative impacts. Self-esteem additionally was associated with humor and the ability to respond positively to both positive and negative situations. Despite the positive effects linked to self-esteem as a barrier to stress, little research has been done in connection to hospital social work using self-esteem as an aid in coping with stress (Boey, 1998).

Internal locus of control is another personality characteristic considered beneficial to stress resistance. The concept of internal locus of control proposes that success and/or failure is within personal control. In other words, a person will be able to cope with stress more efficiently if they believe they have control

over the situation. The idea of control was also used in the concept of hardiness (Acker, 1999; Boey, 1998).

The final characteristic, the Type B behavior pattern, was developed mainly from the findings of the Type A behavior pattern. Type A involves competitiveness, urgency with time and quicker anger and hostility. In contrast, Type B is less likely to view stressful situations as a threat and therefore will react with fewer emotions (Boey, 1998). Like the self-esteem concept, little research has been done in connection to Type B behavior and coping with the stress of hospital social work.

In contrast to the idea of control as a strategy of coping is the idea of balancing engagement and detachment. In a study of caregivers, Carmack (1997), discovered strategies used by healthcare providers who successfully coped with occupational stress. The concept of balancing engagement and detachment allows social workers to be present for others but to be present for themselves as well. Maintaining this balance involves letting go of the outcome; in other words, the social worker is not responsible for the outcome, rather they are only responsible for their work with the patient and the end result, life or death, for instance, is out of their hands. In addition, social workers are not responsible for the problems of the patients; instead, they allow self-determination on the patient's part. Furthermore, decisions on actions must be made with conscious knowledge of what the social worker can emotionally handle at any given time. This may involve setting limits and boundaries in regards to involvement as well as what they are willing or unwilling to do. Monitoring a level of engagement and

detachment is also important as it is impossible to maintain an even balance at all times and adjustments must be made. Practicing self-care is also essential to this balance. In conclusion, Carmack (1997) found that balancing engagement and detachment focuses on the present, acknowledges limits, and makes no attempt to control outcome. It means knowing what can or cannot be changed or controlled, and being aware of personal and emotional needs. The level of engagement is based on what can be handled at any given time. And finally, the importance of self-care is understood.

Gaps in the Literature

While many individuals enter the profession of social work out of a desire to care for others, it is in this caring for others that a great deal of stress is experienced, especially when caring for patients who may be mentally ill, critically ill or facing a critical incident themselves. Along with the emotional stress of caring for these patients, environmental factors encountered in the work place are stressful as well. This stress experienced on a routine basis, if left unacknowledged and unattended, can lead to many factors including CIS, burnout, compassion fatigue as well as PTSD. Therefore, it is essential that hospital social workers are able to cope and be provided with strategies and techniques to aid in coping with stressful situations. These methods of coping may include CISD, counseling, support groups, and education, including education on characteristics within oneself to help in coping.

Historically there has been extensive research on the nature of social work and the stress involved. Consequently there has also been a great deal of research

on effects of prolonged and lingering stress within the social work occupation. More recently, attention has been given to strategies and techniques of coping. Unfortunately little attention has been given to techniques and strategies of coping specifically in regards to the profession of hospital social work and therefore, is a limitation within the literature.

Currently, primary focuses within literature addresses stress response syndromes that may occur when critical incidents are experienced yet remain unacknowledged and un-addressed. Therefore, gaps in the literature include a lack of focus on the benefits of experiencing critical incidents and the ability of hospital social workers to learn and grow from the experience. Instead, literature focuses on the negative effects of stressful experiences rather than benefits that may occur. While this research will address the stressors of hospital social work and emotional reactions, this study will additionally explore the coping strategies and techniques successfully put into practice by hospital social workers that allow them to avoid negative stress response syndromes. Further, this research will explore positive impacts of the experiences.

Summary

In this chapter, a review of the literature surrounding hospital social workers in relation to stress and coping with critical incidents was presented. Topics included: the occupational stress of the social work profession, specifically hospital social work; physical, mental, emotional and occupational effects of experiencing critical incidents; a framework addressing the concepts of critical incidents; and finally, coping techniques and strategies used to withstand

the effects of critical incident experiences. Chapter three will present the theoretical framework of stress and coping.

CHAPTER 3: THORETICAL FRAMEWORK OF STRESS AND COPING

Introduction

In this chapter, the theoretical framework of stress and coping with critical incidents is discussed. Theories presented include: cognitive appraisal of stress; theory of cognitive adaptation; and constructivist self development theory. In conclusion, an application of the theoretical framework to this specific research study is explored.

Experiencing a critical event is stressful; adjusting to the experience is also difficult. Historically stress has been a popular topic in literature and more recently coping with stress has become popular. Researchers agree that it is the coping with stress that determines how a person adapts and what outcome will evolve (McCammon et al., 1987). In the research study of hospital social workers and their lived experiences with occupational stress, a primary focus will be on strategies and techniques of coping with stress that can be and are successfully put into practice by hospital social workers. In order to understand the strategies and techniques used by hospital social workers to cope with stressors, it is first important to understand the theoretical framework of stress and coping. In review of current literature written pertaining to the theme of coping with stress, three theories showing a connection to this research study will be discussed. The most prominent and widely used is Lazarus' theory of psychological stress and coping also referred to as the theory of cognitive appraisal of stress. Subsequently, the theory of cognitive adaptation, similar in some respects to the cognitive appraisal of stress, will be explored. And finally, a more recent theory, constructivist self

development theory will be discussed.

Cognitive Appraisal of Stress

The theoretical background of cognitive appraisal and processing states that when people experience a critical incident, the incident must become integrated into their cognitive representation of the world in order for equilibrium to be restored and for resolution of the experience to occur. This processing may result in a positive or a negative adaptation of their views, beliefs and functioning. Further, during this process of integration a person may experience vivid memories of the event that are emotionally upsetting, therefore, the person may avoid the memories. The phases of active memories and avoided memories can alternate until the incident is integrated (Lazarus, 1966). If this integration process is not successful and a person continues to avoid and experience the memory, PTSD may develop (Werner et al., 1992).

The theory of cognitive appraisal of stress views both the person and the environment involved with the stress and identifies two processes that act to mediate the relationship between a person and their environment, cognitive appraisal and coping. Cognitive appraisal involves an analysis of the stressor, and interpreting a meaning of the situation producing the stress in order to determine whether the incident is effective to their well-being. Cognitive appraisal is composed of a primary and secondary appraisal. Through the primary appraisal a person identifies stressors in their environment. In this phase, stressors are defined as anything that may be deemed as threatening to a person's well being. When these stressors are encountered, the secondary appraisal emerges. In

secondary appraisal, ways of coping, reducing or eliminating the stressors, in order to prevent harm, are considered. This phase involves the process of coping, defined as the way a person manages emotions and events that are considered stressful (Folkman et al., 1986; Lazarus, 1966; McCammon et al., 1987). The ways of coping may include an approach or problem-focused coping where information and support are sought and decision-making and direct action take place. Alternatively, an avoidance or emotion-focused coping may take place where the stressors are reinterpreted to alleviate the perception of there being a stressor (Lazarus, 1966; McCammon et al., 1987; Mahat, 1998; Werner et al., 1992). Within the theory, the approach or problem coping focus would assist in the integration of a critical incident as it promotes a situation to be more controllable whereas the avoidance or emotion-focused coping denies rather than addresses the stressor (Folkman et al., 1986; Werner et al., 1992).

Theory of Cognitive Adaptation

With its foundation based on the theory of cognitive appraisal, the theory of cognitive adaptation expands by addressing the phenomenon whereby a person can withstand suffering and stressors and still maintain a quality of life equivalent to, if not exceeding, prior life satisfaction. Developed by Shelley Taylor, the theory proposes that in the face of critical incidents, adjustment will revolve around three themes: meaning, mastery and self-esteem (Taylor, 1983). First, a search for meaning of the incident will transpire. The meaning phase attempts to understand the critical incident and find a reason for its occurrence as well as how it has altered a persons life. The second phase involves an attempt to regain

mastery over the incident. In the mastery phase, a person not only searches for control over the incident but also over his/her life as well. Searching for a way to manage with the incident, as well as a way of prohibiting a recurrence, takes place in the mastery phase. Finally, an effort to regain a positive self-esteem and to feel good about one's self takes place in the third phase or the self-enhancement phase. Despite a lack of responsibility for the critical incident, esteem may still be affected and therefore, feeling good about one's self will need to be enhanced (Taylor, 1983). "Healthy survivors eventually find something to value in the traumatic experience: lessons learned, new priorities, a newfound awareness of their strengths" (Janoff-Bulman, 1997).

Constructivist Self Development Theory

Similar to cognitive adaptation theory, constructivist self development theory addresses the concept of posttraumatic growth. Based on the premise that people can draw on a critical incident to gain wisdom, meaning, and make positive changes in their lives, constructivist self development theory (CSDT) explains negative changes in the face of critical incidents as well as positive changes resulting from the integration and meaning-making of the incident by acknowledging individual differences and uniqueness (Saakvitne et al., 1998).

Furthermore, CSDT asks the question of why some people survive and thrive in the face of adversity while others seem to crumble. In response to this question, individual responses to critical incidents are explored including individual meaning ascribed to the incident, an individual's age, past experiences, expectations, biological and psychological resources, and social, cultural, and

economic background. CSDT acknowledges that individuals are unique and therefore are affected in unique ways by critical incidents. In other words, different people will respond differently to similar events (Saakvitne et al., 1998).

CSDT addresses and describes the impact of critical incidents on the development of individuals by observing five areas in which individuals may be affected by these incidents. The first area is the frame of reference or the way one understands and makes meaning of the world. This area includes spirituality. The second area involves self-capacities or the ability to recognize, tolerate and integrate a connection with self and others. The third area pertains to ego resources or the ability to meet one's psychological needs and care for self. Fourth, central psychological needs are involved including: safety, trust, control, esteem and intimacy. And finally, sensory experiences may be affected as the fifth area (Saakvitne et al., 1998).

Application of Theoretical Framework

The theory of cognitive appraisal of stress, theory of cognitive adaptation and constructivist self development theory, are three current theories that explain how individuals cope with stress. In addition, these three theories will act as groundwork for helping to define, explain and understand ways in which social workers cope with stress while researching the lived experience of hospital social workers. Through the theory of cognitive appraisal of stress it will be possible to view the various coping styles of hospital social workers to understand if stress is being addressed through an approach or problem focus, or if the stress is being denied through an avoidance and emotion focus. In addition, the theory of

cognitive adaptation will be used to understand the phases a hospital social worker may go through to integrate stressful experiences into their reality base in order to make meaning of and to control the incident as well as regain their self-esteem. And finally, constructivist self development theory will be applied to determine at what area and level stress is affecting a hospital social worker. This will be done by specifically recognizing each social worker as an individual who will react and place meaning to an incident based on his or her unique characteristics and experiences and therefore, be affected by a critical incident in a unique way. In addition, by using three theories, variations in hospital social workers coping methods will be acknowledged, validated and better understood rather than attempting to fit all coping methods of hospital social workers into one framework.

Summary

In this chapter, a theoretical framework in regards to stress and coping was presented. Additionally, an application to the current research study was provided. In the following chapter, methodology of the study is addressed.

CHAPTER 4: METHODOLOGY

Introduction

In this chapter, the research question, design, and methodology used to conduct the study are presented. Further, important concepts, variables and themes explored in the research are conceptually and operationally defined. Subsequently, characteristics of the population studied will be described along with sampling procedures used. Procedures used to verify the quality and trustworthiness of the data collected will then be discussed. Next, the questionnaire and interview guide will be presented along with pretest measures taken and procedures implemented for data collection. Methods used for analysis of data collected will likewise be explained. In conclusion, procedures to protect human subjects will be defined.

Research Question(s)

This research study investigates the lived experience of hospital social workers relating to stress and coping methods used to deal with the impact of stressful events. The research questions raised by this study are: 1) what is the lived experience of hospital social workers relating to critical incident stress? 2) How do hospital social workers cope with the impact of stressful events?

Research Design

This qualitative study is inductive and exploratory by nature using an in-depth interview of seven hospital social workers. A semi-structured interview format, lasting 30 – 45 minutes and audio-taped for transcription purposes, was used to gather data. The interview consisted of open-ended questions (Appendix

C) in order to gain in-depth, detailed responses that allows for deeper understanding and meaning of personal lived experiences. Strength of the design is the ability to reveal participant's thoughts, feelings, experiences and perceptions through their direct quotations (Patton, 1987). In addition, variations of individual differences within the participants may be explored.

Conceptual and Operational Definitions

Hospital Social Worker is defined as a licensed social worker with work experience in a hospital setting including medical floors, hospice, mental health units or the emergency department. Variables of participants, such as age, gender, marital status, parental status and length of employment will be considered while observing the differences of impact and effect of stressful incidents.

A critical incident is defined as any situation that causes overwhelming, dramatic, emotional reactions such as anxiety, helplessness, anguish, guilt or grief. Further, a critical incident will have the potential to interfere with the ability to function normally. In this study, participants define what represents a critical incident for them, and therefore, the definition of a critical incident may vary between participants.

Critical incident stress is conceptually defined as a set of physical, cognitive and/or emotional reactions or symptoms that occur due to a critical incident. Furthermore, these reactions may impair a person's natural ability to cope.

Coping is conceptually defined as a person's cognitive and behavioral change that is made in attempts to manage external and internal conflicts and

stressors. Operational strategies for coping may include attending critical incident stress debriefings, grief workshops, counseling and/or educational workshops. Other strategies for coping, as defined in the literature, are personal traits and behaviors. Various themes and methods of coping include: cognitive appraisal of stress which consists of interpreting and giving meaning to the critical incident; cognitive adaptation, which also begins by gaining and placing a meaning to a critical incident but expands to include gaining control over the critical incident as well as renewing a damaged or altered self-esteem; and finally, the concept of posttraumatic growth states that coping includes the ability to gain wisdom, meaning and make positive changes in one's life despite and partially due to critical incidents.

Study Population

This research study attempts to better understand the experience of hospital social workers that are or have been exposed to critical incidents and the effects of the stress and coping with such incidents. Requirements of participants include being a licensed social worker and experience in a hospital setting. The study population consisted of seven women who work as hospital social workers. The participants work in critical care settings where they are exposed to dramatic situations, including critical incidents that have the ability to cause overwhelming emotional reactions. Settings or units the social workers have experience in include: hospice, psychiatric units, intensive care, oncology, and the emergency department.

Study Sample

The research study, which looks to understand the lived experience of hospital social workers that experience stress and coping of critical incidents, required participants who are licensed social workers with experience in critical units of a hospital setting. In order to locate participants who meet these criteria, a professional in the field of hospital social work identified potential participants. Once potential participants were identified, a letter of introduction (Appendix A) was distributed. The first seven people to contact me with an interest in participating in the study were designated as participants. Therefore, participants were recruited through a non-probability, purposeful sampling.

Measurement

This qualitative research study searches for deeper meaning of the lived experience of hospital social workers experiencing stress and coping with critical incidents and, therefore, a standard scientific criterion for establishing quality and verification of research does not apply for this study. In attempts to answer the question: "How do we know that the qualitative study is believable, accurate, and 'right'?" Cresswell (1998) explores standards that have been established by qualitative researchers to ensure quality and validity in qualitative research.

The first set of standards presented by Cresswell (1998) was designed by researchers Howe and Eisenhardt (1990) and include five standards. The first standard states that it is necessary to ensure that it is the research question that is driving the data collection and analysis. Second, data collection and analysis techniques must be applied in a technical sense. Third, the researcher's

assumptions must be made clear. Fourth, the study must have overall warrant with theoretical explanations included. Fifth, the study must answer the "so what?" question as well as fulfill ethical questions of confidentiality, privacy and truthfulness and full disclosure to and with participants (Cresswell, 1998).

Following Howe and Eisenhardt's (1990) standards, eight standards established by Lincoln and Guba (1985) are presented. The standards begin with "inquiry community," which involves guidelines for publication. Next, "positionality" refers to the need for honesty or authenticity in regards to the position of the text as well as the position and convictions of the author. In addition, positionality states that information gathered cannot always be generalized to similar individuals or groups across time and contexts due to issues in sampling procedures. "Community," the next standard, acknowledges that research "takes place in, is addressed to, and serves the purposes of the community in which it was carried out" (Cresswell, 1998). The standard of "voice" refers to the narration of participant's stories and allows participants to be heard rather than silenced, disengaged or marginalized. "Critical subjectivity" requires the researcher to have heightened self-awareness and to be conscious of personal psychological and emotional conditions throughout the research process. "Reciprocity" as a standard, involves an intense sharing, trust and mutuality between the researcher and participant(s). The standard of "sacredness" places a requirement on the researcher to respect the relationship, collaboration, and egalitarian aspects of the research. Finally, the standard of "sharing of the privileges" requires the researcher share in any wealth that occurs due to the

research.

Cresswell (1998) also discusses the importance of "trustworthiness" in qualitative research and presents eight verification procedures, suggesting that a minimum of two be used in any given study. First, "prolonged engagement and persistent observation" involves learning about the culture, building trust and also checking for and verifying misinformation. "Triangulation" involves using multiple sources, methods and theories to gain corroborating evidence. "Peer review or debriefing," offers an external check through discussions of the research study with "peers" who will "critique" specifics of the study. The procedure of "negative case analysis" states that the hypotheses may be refined and revised to allow cases to "fit" into the study. "Clarifying researcher bias" requires the researcher to acknowledge past experiences, biases, prejudices, and orientations that may shape or affect the current study. "Member checks" allow participants to review data, analyses, interpretations and conclusions in order to judge accuracy and credibility of the information as presented by the researcher. "Rich, thick description" will allow for readers to transfer information to other settings due to shared characteristics. Finally, "external audits" consists of a person outside the study who can examine the process and the product to ensure accuracy. This procedure makes certain that the data supports the findings, interpretations and conclusions.

In order to ensure "validity and quality," measurements of this study began by making certain the research question was "driving" the data collection and analysis. Further, data collection and analysis were conducted in a technical

and professional manner guaranteeing confidentiality, privacy, and truthfulness. The merit of the study was made certain through a thorough literature review and theoretical findings. In addition, trustworthiness of the study included the verification procedures of prolonged engagement and persistent observation as well as an external audit.

Prolonged engagement and persistent observation was implemented through the researchers work as an intern within a hospital setting. By interning as a hospital social worker in various settings, first hand experience of critical incidents as well as the role of the hospital social worker was gained. Further, this experience assisted in learning about the culture as well as allowing for the ability to verify and clearly understand information gathered in interviews with participants.

External audits of the study occurred through the process of working with a person outside the study. In this manner, the procedure of the study was examined and accuracy was made certain.

Data Collection

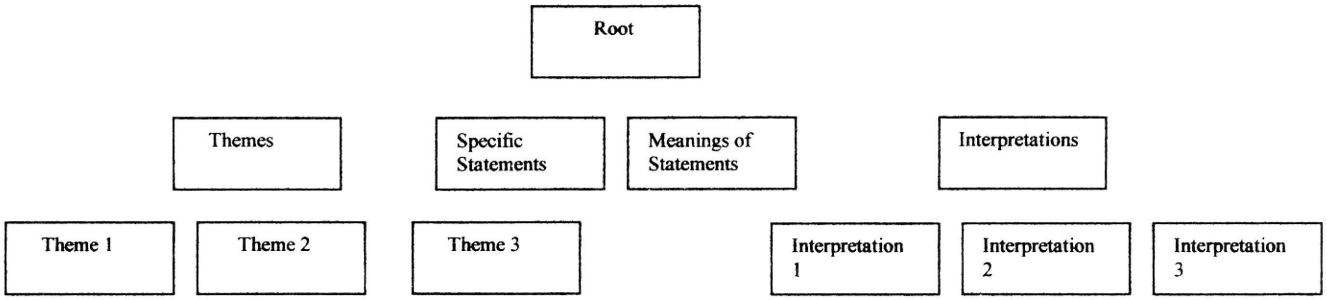
The first seven people to respond to the letter of introduction (Appendix A) were contacted to be participants. After reviewing and signing a consent form (Appendix B), a 30-45 minute, semi-structured, interview was conducted at a date and time that was convenient for both the researcher and the participant. The interview was audio taped, with the permission of the participant, for the purpose of transcription. Furthermore, the interview was conducted at a location that assisted in the comfort of participants. The semi-structured interview was guided

by a questionnaire (Appendix C), which was pretested on peers, as well as a hospital social worker not involved with the study.

Data Analysis

Transcribed interviews, the "root" as described by Cresswell (1998), were reviewed in their entirety several times to get a sense of the narrative as a whole. Subsequently, the transcripts were "broken" into parts to discover key concepts or categories (codes) of information that reoccur. Once these codes were established, a description of experiences shared by the participants was established. Next, themes and patterns of regularities were developed for further interpretation. Participant statements were classified for meaning at this stage as well. Consequently, interpretation involved answering the questions "what happened" and "how was it experienced." A sense and essence of the findings was interpreted as well. This process, according to Cresswell (1998), involves: "moving from the reading and memoing loop into the spiral to the describing, classifying, and interpreting loop" (p. 158). Furthermore, participants' direct statements, along with findings in the literature, support interpretations and themes.

Table 4.1: Tree Diagram for Data Analysis



Note: From Qualitative Inquiry and Research Design: Choosing Among Five Traditions, by J.W. Cresswell, 1998 Thousand Oaks, CA: Sage.

Protection of Human Subjects

In order to protect participants, the research proposal was reviewed and approved, prior to the study, by the Augsburg College Institutional Review Board (IRB # 99-72-3). Participation for the research study was completely voluntary and participants were given the option to withdraw from the study at any time without consequence. Additionally, each participant signed an informed consent form (Appendix B) prior to the interview and data collection. The consent form informed participants of the purpose of the study, study procedure, possible benefits as well as potential risks involved, such as painful emotions that may arise due to the nature of the topic. Participants were provided with a phone number of a resource that could be utilized for support in the event that painful emotions or stress does occur due to the research and interview questions. Any identifying information from the interview has been altered or removed to ensure participant privacy. No names or identifiable information about participants have been used. Audiotapes and transcribed texts were kept in a locked drawer in the researcher's home and were destroyed by August 31, 2000 to assist in confidentiality. Furthermore, the only people who had access to the audiotapes and transcripts were the researcher and the thesis advisor.

Summary

This chapter discussed the design method, which was used in the research study of the experience of hospital social workers and their experience of stress and coping with critical incidents. Key concepts and themes were likewise

defined. Subsequently, characteristics of the study population were identified along with the procedure used to recruit participants. Procedures were next addressed, including measurement issues, data collection procedures and data analysis measures used. And finally, measurements used to ensure the protection of human subjects were addressed. In the next chapter, results of the study will be presented.

CHAPTER 5: FINDINGS

Introduction

In this chapter, results of the study are presented. To begin, demographic characteristics of the participants are described. Next, participants' definition of a critical incident is presented. Consecutively, critical incidents experienced by the hospital social workers are presented in response to the first research question: what is the lived experience of hospital social workers relating to critical incident stress? Furthermore, the critical incidents are presented within three themes in which they are categorized: life and death situations; personal connections; and politics of the environment. Common coping techniques practiced by participants are addressed in response to the second research question: how do hospital social workers cope with the impact of the stressful events? Coping techniques again are presented according to categorized themes: support of peers and colleagues; a balance in life; education and debriefing; and personal fit. And finally, the personal and professional impacts of critical incident experiences are described.

Profile of participants

The participants in this study include seven female social workers currently working in a hospital setting. Years of social work experience range from three to forty-five years and include hospital experience in the emergency department, maternity, oncology, telemetry, adult mental health and hospice. Of the participants, six are married and five have children.

Critical Incident Defined

In searching for the experience of hospital social workers relating to

critical incident stress, participants were first asked to describe what the term "critical incident" means for them. Participants defined a critical incident as experiences, situations or events that may cause personal trauma, physically or emotionally or an "emotional uproar" that may affect how they do their job if gone unrecognized. Further, a critical incident was defined as an experience with a person or family the social worker may have a special connection to; for example, a social worker stated: "a critical incident to me would be something within an individual's life or within the family that I felt a real connection to or that triggered something within my life or some experience that I have had."

And finally, a critical incident was also defined as any experience that can cause and elicit a change within the social worker. Another social worker said: "a critical incident is something that has affected me emotionally and has changed me…it has touched my heart, and my feelings."

Types of Critical Incidents

In connection with their definition of a critical incident, participants were next asked to recall and describe one or two incidents they had experienced that resulted in eliciting a strong emotional reaction. Participants' responses were transcribed, analyzed for similarities and themes, and grouped by category.

Life and Death

The most frequently cited experience perceived to be a critical incident for participants involved life and death situations. Three participants recalled the death of an infant or young child, as causing emotional reactions. In one situation, the social worker recalled working with a mother experiencing the

trauma of losing a 15-month old baby to SIDS: "it was very emotional down there in the ER and I was not prepared to see a child who had died and it was a nightmare, just a nightmare for everybody, the whole staff...it was a high crisis time. I lost a lot of sleep over that one." The participant recalled the event as being traumatic and taking a while to get over. Additionally, she remembered having it affect her not only at work but remaining on her mind at home as well as losing sleep.

In another situation, a social worker was involved with a case of Munchausen by Proxy where she suspected that the child's multiple illnesses were being caused by his mother. The social worker took measures to intervene, including making a report to child protection, and attempted to gather support from others involved with the mother. Unfortunately, attempts to intervene and solicit help from others involved in the family system failed and the child died. Learning of the child's death, the social worker recalled her reaction: "I am furious, absolutely furious and devastated...the hard part, why I think it was a critical incident, was the trauma of not only that this innocent kid died but that I knew and nobody was willing to listen, and also the struggle of, 'did I do enough, what else could I have done?'"

Emotional reactions to patients' deaths are not isolated to infant or children; deaths of adults likewise create emotional reactions for hospital social workers. Moreover, on many occasions the social worker will build a relationship with a patient and their family. This connection and relationship further intensifies the heart-felt emotion at the death of the patient. Often, the emotional

experience of losing a patient intensifies when the social worker has felt a strong connection and bond with the person, especially when her life has been touched or affected by their work with the person. One participant recalled the effect a patient had on her life: "...she taught me about what it means to be yourself right to the end, to be valiant, to be courageous and be real and authentic. And right to the end she did not lose the essence of who she was. I just got so close to her that I just really grieved her and I got real close to her family too...I still think about her a lot."

In addition to the emotional experience of a death of a patient, social workers at times find themselves with the patient and family at the time of death. One participant recalled being asked by the family to come to their home upon the death of their family member. She recalled: "I disconnected the tubing and closed his eyes and we (the family and social worker) prayed and talked and I must have stayed with the family for three hours...I think of them from time to time."

Personal Connections

Feelings of having a personal connection to the patient were cited nearly as frequently as life and death situations in relation to emotional experiences. For many participants, this personal connection involved the characteristic of being a mother and participants found this connection contributed in emotional feelings. In one experience, the social worker was faced with working with a new mom whose twin babies were born addicted to cocaine. In recalling the experience, she spoke of the connection of being a mom and her emotional reaction to the

situation: "critical situations for me are working with kids, they are much more emotional for me. I think it is the mom-bond thing, having my own children; it's a tender spot…with this mom I had to check myself for how I felt. I didn't want to be mad at her while my first reaction was, 'how could you have done this to these poor tiny babies'…I had to put that aside to help her."

In another situation, a social worker found herself working with a family where the patient died, along with twin babies, due to a complicated birth. Again, the participant recalled the emotional reaction she felt and how she related it to herself as a mother: "I will never forget that experience and all that it brought up to me. Just being a mother and having children…she finally had her children and they couldn't live a life together."

For other social workers, the personal connection occurs due to personal experiences they have encountered in their lives. In these situations, experiences encountered at work can elicit memories of their personal experiences. In one situation a participant was reminded of her own battle with cancer when she was involved with a woman facing a recurrence of breast cancer: "…she was a fairly young woman who had a recurrence of breast cancer. It was a surprise to the woman and her family and it freaked me out because I have a history of breast cancer myself…even though it's been a while, it sort of came back." In another incident, a social worker was faced with a patient and his wife experiencing a situation similar to an encounter she had faced with her brother: "It just reminded me of my brother who was in good health and he had a severe stroke and has been in a nursing home ever since – a sort of parallel situation. I had to register with

myself that this is a patient, this is not my brother and I am not his sister."

For a participant, a special connection can occur based on life similarities and therefore, it is not one specific incident that causes emotional reactions for her but the connection and relationship as a whole. The emotional reactions and experience are further intensified when the relationship is formed due to an end-of-life situation. One such experience the participant recalled was with an older gentleman and his wife. The participant remembered: "...this older gentleman just brings it back...this couple is the family I was raised in...listening to them talk...I can relate, and they can relate, because our experiences are so similar. There are people we get closer to because of this type of thing...older men touch my heart because I was real close to my dad." Another participant found a connection based on age. In the situation recalled, the participant was involved in a family conference for a patient who was suffering from anorexia. She recalled: "I just remember thinking: 'wait a minute, I only want to talk to people about hospice to people who are dying,' and here is a girl who is trying to end her life and she wants to be on hospice and to see somebody who is similar to my age so thin and wanting to end her life, it was a shock to me. This is so wrong and then to have her family support it, it was a shock to me."

Politics of Environment

The third and final category of critical incidents described by participants involves the environment in which hospital social workers must carry out their role. For one social worker, a critical incident experienced involved the hospital staff and politics of the work environment. She remembered a critical incident to

be: "working with the staff...the politics in working in a hospital system when you are going one direction and a doctor is going another...and the lack of control I have over the situation." Specifically, the case the social worker went on to describe involved a patient presenting to the hospital with psychotic features including self-harm issues. As the hospital social worker, the participant had been asked to assess the patient and give a recommendation. Upon assessment the social worker recommended placement into the mental health unit, the doctor disagreed with this and the patient was discharged home. A short time later the participant received a call from the patient's family reporting that he had overdosed. Her thoughts were: "I think dealing with the politics affects me...it just shows that they ask for our recommendation and our input and when it comes right down to it they are ready to make the decision themselves...and they have the ultimate decision."

Another participant remarked on the lack of support that can be felt within the hospital setting in the time of crisis. Specifically in one situation the social worker found more support outside the hospital and saw the hospital as overly focused on their "appearance." She said: "I will say that I got more support from out of the system than in the system, and I think it is sometimes difficult when you are in a situation where legal ramifications can happen and instead of focusing on the caregivers and how we are handling this, we sometimes spend more time figuring out...what are we going to say...you know, covering your butt...and sometimes we lose sight or focus on how to debrief people from emotional situations."

Coping Techniques Employed by Hospital Social Workers

Once a critical incident was described, participants were further asked to share how they coped with the experience. Again, answers were transcribed, analyzed for shared themes, and categorized. These themes include: support of peers and colleagues; a balance in life; education and debriefing; and personal fit.

Support of Peers and Colleagues

While all participants described a number of techniques used to cope with and through stressful situations, all seven participants shared the technique of processing and using colleagues and peers for support. Being able to talk with co-workers was a shared coping mechanism for all participants. One participant said: "being able to talk with co-workers, just to be able to come in and be in tears and be able to say, 'this is so difficult,' just to have somebody to listen and process." Participants reported and stressed the importance of having colleagues to talk to whether it is to process a stressful event, cry, complain or search for insight and assistance in difficult situations. While all participants additionally reported family and friends as important support systems, each also stated that co-workers are much more effective for processing situations because they can best relate. "People at work know where you are coming from, they can actually relate to what you are saying and give input." Participants reported having friends and family who were strong supports and had on occasions listened to their emotional reactions, yet, participants also reported that family and friends often do not fully understand the situations due to confidentiality or simply a lack of knowledge in regards to the role of hospital social work. Likewise, family and friends get "tired

of hearing about it" reported two participants. For these reasons, participants stressed the need for support of colleagues in their emotional work.

A Balance in Life

The second most common theme participants shared for coping with stressful situations involved a balance in their life. This balance most often was described as the importance of their personal life and keeping work separate. In other words, having a clear boundary between their professional life and personal life. For all participants, personal life included time with family, often children or grandchildren and also time with friends. The importance of personal life was reported by one participant who said: "I get my energy from my home and my family…I get my energy so I can be fresh for my patients."

A healthy life style and self-care was also included in this balance in life. Four participants spoke of the importance of exercise to relieve anxiety as well as to rejuvenate their energy and remain healthy. Mental health days when feeling "stressed" were also reported as an important coping measure. For one participant a mental health day involved time to do "absolutely nothing." Another participant reported, "taking a lot of tubs (baths)" as a means of relaxing or reducing stress. For a number of participants, the hospital setting was not the only area of social work practice in their life. Other involvement included volunteer work, developing programs, working for a crisis unit, teaching social work classes, and private practice therapy. One participant said that this added dedication to social work serves to: "counter balance and absorb the hospital work."

Another balance in life involves spirituality. Furthermore, three participants credited their spirituality as playing a vital role in their work with critical incidents. Therefore, spirituality was not only seen as a part of their personal life but as a part of their work and role as a social worker as well. Prayer, like spirituality, also played a significant role in their work and coping with critical incidents. For some, prayer was included in their direct work with patients and families. Prayer was also used as a way to let go of the emotions and stress when feeling emotionally burdened. One participant said: "when I am concerned about something…instead of letting it just grasp me and take so much of my energy and my mind, I can hand it over, I pray and I know it is where it belongs and with "amen" I can let it go."

Education and Debriefing

For one participant the process of continual education and self-development was used as a coping technique. This education was both formal and informal and included discussions and supervision with colleagues and supervisors, as well as attending seminars in order to learn new techniques, theories and approaches. In order to feel adequate and qualified for her role, as well as feeling able to do her best work for patients, one participant stressed the need to have a complete knowledge base surrounding her role. This knowledge includes learning specifics of the medical field and medical terminology on an ongoing basis.

Debriefing was also mentioned as important to coping with critical incidents. One participant described a "debriefing" she attended after a critical

incident and the support it gave her to process the event with other professionals who were involved with the incident. For another participant, "debriefing" was not seen as something that needed to occur in the procedure of a "formal debriefing seminar put on by professionals" but rather was viewed as the time she spends processing with her colleagues and peers on a day-to-day, "informal" basis.

Personal Fit

A final description and theme of coping was the idea of being personally fit to the role within the hospital. One participant described herself as being called to her role and said: "I don't believe that I selected hospice, I believe hospice selected me." The importance of this fit was further stressed by other participants who described feeling called to their role and place within the hospital as well as a feeling of how important and vital their role is. One participant recalled working in various areas of the health care system in which she was not comfortable and the importance of knowing personal style in order to work in an area where you can do your best for the patient. She went on to acknowledge that certain personalities and work styles fit different areas of the health care system, and therefore, it is important to work in the area best suited to personality. A participant also remarked on being fit to her hospital work and described the "excitement" she feels in her role and calls it an "adrenaline rush." Another participant spoke on the importance of fit, not only for the work that can be done for the patient, but also for the personal benefits as well: "if any social worker is choosing a career and wanting to go out there professionally, there is a

variety of things they can go into, but I would say, just don't look for the financial end...look for what touches your heart, what you can do to make a difference, then it is rewarding."

Impact of Experience

In searching for a deeper understanding of the experience of coping with critical incidents, participants were asked how the experience impacted or changed them personally as well as professionally. Participants next were asked if they ever felt compelled to leave the health care system or social work practice. In response to the latter question, participants unanimously reported that while there were some very difficult days and situations, they have not felt the desire to leave their role within the health care system or social work practice.

Likewise, negative impacts of critical incident experiences were not addressed by participants; rather than experiencing a "burnout" or desire to leave their social work role, participants most frequently responded that stressful or critical incidents served as a means for growth and development. One social worker stated: "it is the process of growth, the process of my growth as a human being first of all and then as a social worker...you can't do this work and journey with these people through this time without coming away with something." One participant reported developing "instincts and a deeper sensitivity" to patients and families life experiences. Having experienced the incident of the SIDS death, the participant reported being better prepared to handle and support parents in future experiences. Still another reflected on the continual increase in her knowledge base, which further increased her "courage and inner strength to handle difficult

situations." For three participants, the experience of critical incidents strengthened their spirituality and further created a deeper faith.

Participants also reflected on their professional development over years of social work practice and many experiences with critical incidents. One recalled entering social work with the attitude that she could do anything and nothing would bother her and when something did, she often did not recognize it. Over the years, this participant developed a better sense of where something triggered a reaction in her as well as recognizing that it is important to acknowledge the feelings and act accordingly. Another participant recalled entering the health care system as a new social worker with a high energy and aggressive approach. For this social worker, the experience of critical incidents has changed her approach to process situations more thoroughly and to be less aggressive. Moreover, after the "Munchausen" experience, the social worker stated that she has become very "in tune" to situations involving children and suspected abuse or endangerment and makes certain that every measure is taken to ensure their safety.

Personal impacts of critical incident experiences again had a positive focus. Participants described the personal impact of critical incidents as creating a feeling of being "privileged to walk with people in such a private place," as well as feeling honored and humbled to be a part of the lives of people during their critical life experiences. One participant reflected on her work with people during traumatic times and said: "I don't see it as a downer doing this work, it feels so opposite. It is an honor to be doing what I am doing, meeting people where they are and journeying in whatever way…it keeps me humbled."

Summary

This chapter presented findings from the data analysis. In summary, participants described experienced critical incidents as being those involving life and death situations, situations where the social worker had a personal connection to the patient or family, and the politics of the environment. Coping techniques involved: the support of peers and colleagues; a balance in their life, which includes a full, separate personal life; education and debriefings; and finally, a feeling of being "fit" to their role in the health care system. In conclusion, the impacts of critical incident experiences were presented.

Chapter six will present a discussion on the findings of the study in relation to current literature involving stressful experiences and coping techniques of hospital social workers. The final chapter will also describe strengths and limitations of the study. In conclusion, implications for practice and policy, as well as implications for further research will be offered.

CHAPTER 6: DISCUSSION

Introduction

The final chapter will present a discussion of the major findings of the research study and connect prominent points to the literature. Strengths and limitations of the study will likewise be presented. And finally, implications for social work practice and policy, along with implications for further research will be discussed.

Major Findings

The purpose of the study was to find the lived experience of hospital social workers and their experience and coping with critical incidents. Specifically the study asked: what is the lived experience of hospital social workers relating to critical incident stress? And, how do hospital social workers cope with the impact of stressful events? To answer these questions, participants were asked to define what a critical incident is for them; to recall and describe one or two lived experiences; how they coped with the experience; and finally, how the experience impacted them personally and professionally.

Critical Incident Defined

Participants defined a critical incident to be experiences, situations and events that have the potential to cause physical and emotional trauma for the social worker. Their definition also included the possibility of a change or alteration in their work due to the experience. Participants' definition is consistent with the definition by Mitchell (1983) and Spitzer and Burk (1993), which states a critical incident is any experience that causes emotional reactions

and have the potential to interfere with a person's ability to function normally. Mitchell's (1983) study found that critical incident stress might not occur only due to one situation or experience; rather it may occur due to an accumulation of events. Participants of this study likewise reported stress or emotional reactions often occurred in connection to multiple experiences and events rather than one specific traumatic event.

Types of Critical Incidents

The most frequently described critical incidents, life and death situations and personal connections to patients and families experiencing trauma, is consistent with situations found by Dillon (1990) and Sze et al. (1986) to cause occupational stress in hospital social workers. Dillon (1990) found an increased stress for the hospital social workers due to their involvement with patients in distress caused by mental illness, terminal illness and traumatic experience. This study is consistent to the findings of Dillon's (1990) study.

In a study on the role of the social worker in the hospital setting, Keigher (1997) found that social workers can feel "misunderstood" as well as "an outsider" due to the "foreign language" of the medical terminology and a possible conflict of goal for the patient. Likewise, this study also found a stress in working in a "host setting" where doctors have the ultimate decision regardless of the social worker's recommendation. Findings of this study regarding situations presenting stressful experiences for hospital social workers, which include the prevalence of life and death situations, personal connections to people in crisis, and politics of the environment, is consistent with the literature.

Inconsistencies, on the other hand, involve the findings of Cwikel et al. (1993) and Sze et al. (1986) in which hospital social work stress is in connection to a feeling of inadequacy, low level of remuneration, and a constantly changing work environment. Results of this study do not support these areas as stressful characteristics of the hospital social work role according to responses of participants. Moreover, unlike the findings of Dillon (1990), participants did not report working with clients who are "unpopular" due to homelessness, less resources, or being elderly as an area of stress.

Coping Techniques

The most universally applied coping technique exercised by participants was the support and ability to process with peers and colleagues. Participants unanimously identified the importance of co-workers who understand and can relate to the emotional reactions that arise due to stressful experiences. While little was found in the literature in connection to the "informal" support of colleagues, the concept of needing to process with others in the field who understand the experience is the prevalent theme in Mitchell's (1983) "formal" critical incident stress debriefing process. Hinds et al. (1994) and Hine (1996) likewise found the importance of support systems to allow an "acknowledgement and facilitation" of grief and stress-related emotions. Again these support systems were recommended on formal levels, such as memorial services, education on grief and stress, and support groups. Additionally, Fursland (1998) reported the need for hospitals to facilitate coping with stress through support by having: adequate numbers of staff to allow the availability of peer support; promote

"mentoring" relationships; allowing informal group discussions; and by creating a positive atmosphere allowing cohesiveness.

Having a well-balanced life in which participants had a full personal life outside the health care system was the second most frequent response to coping techniques. In a study of hospital caregivers, Carmack (1997) found that successful caregivers balanced "engagement and detachment," whereby a caregiver could be present and dedicated to the patient yet did not become enmeshed due to clear boundaries as well as a presence and dedication to themselves. This "presence" for self occurred through acknowledging personal limits, not taking responsibility for patient's lives, and self-care. Results of this study are consistent with Carmack (1997) as participants reported the necessity of clear boundaries with their patients as well as the need to acknowledge that it is the patient's "crisis" not their own. Participants likewise addressed a clear boundary between professional and personal life. Furthermore, participants stressed the energy they receive from family, friends, hobbies and interests outside of work. The need for spirituality was also a prevalent coping technique for participants. According to Saakvitne et al. (1998) and the theory of constructivist self development, the ability to cope with critical incidents is affected by an individual's level of spirituality as well as their ability to meet self-care needs.

The need for continual education and debriefing opportunities is widely discussed in the literature. To begin, Mitchell (1983) has developed a lengthy debriefing process to aid in coping with stress. Likewise, Hinds et al. (1994) and

Turner (1997) conducted studies on various educational programs as well as debriefing formats and found hospital employees coping skills increased with even a minimal amount of participation in education and debriefing opportunities. The need for continual education and availability of debriefing opportunities is further supported by results of this study.

Participants additionally spoke of the necessity to work in an area of the hospital that fits a personality or work style. While participants did not define specific personality characteristics, Boey (1998) defines these various characteristics as hardiness, self-esteem, internal locus of control and a Type B behavior pattern. The need for support of peers, a balance in life, education and debriefing, and a fit to one's role, as found in this study, is consistent with the literature.

Impact of Experience

Current literature surrounding occupational stress significantly reports negative reactions and the negative impact of critical incident experiences to include burnout, compassion fatigue, and posttraumatic stress disorder. The literature also supported the concept that the stress of hospital social work has the ability to push individuals to leave their role in the hospital or social work altogether. Results of this study do not support the literature involving negative reactions and impacts to hospital social workers. Participants collectively and vigorously stated that despite very stressful and emotional experiences they had no desire to leave their role or social work. Rather than feeling burnout, fatigue or posttraumatic stress, participants found critical incidents impacted them as a

means for personal, professional and spiritual growth. Furthermore, participants of this study viewed their role and work with patients through critical times to be an honor and a privilege. However, this study only interviewed seven hospital social workers.

This expression of finding a meaning and growth due to the stressful experience supports the theory of cognitive appraisal of stress, which proposes that stressful experiences will result in a change of views, beliefs and functioning of the person. Further, the theory states that coping involves an interpretation of the event to determine its effect and meaning. This is consistent with one participant's response that, in order to cope with a stressful experience, she must allow the feelings and event to "flow through her" in order to be aware and gain an understanding of the meaning of the experience for her life: "what is there for me in this...what am I to see, to learn on a new level?" In this way, according to the theory of cognitive appraisal of stress, the stressor is reinterpreted as having a meaning in place of being a stressor.

Like the theory of cognitive appraisal of stress, the theory of cognitive adaptation further stresses the need to place meaning to stressful experiences in order to master the stressor and gain a "self-enhancement" or growth through a lesson learned, a new priority or an awareness of personal strength. Further, constructivist self development theory (CSDT) is based on the premise that people draw on critical incidents to gain wisdom, meaning and to make changes in their lives. CSDT proposes five areas within an individual in which development occurs due to critical incidents: spirituality, self-capacities, ability to

meet personal and psychological needs, and finally sensory reactions. Participants' responses to the impact of critical incidents in their lives are consistent with these theories involving stress and coping. Participants, consistent with the theories, found a personal and professional growth due to their experiences. Personally, participants experienced spiritual growth and commitment as well as feelings of being honored and privileged to be with people in such personal and private times. Participants also spoke of lessons they had learned about life due to their work with people. Awareness of personal limitations and self-awareness was also advanced due to critical incident experiences. Professional growth included a deeper knowledge, understanding and confidence of their ability as a social worker. In addition, participants felt better prepared for future work due to their experiences.

Conclusion

Strengths and Limitations

A primary strength of the study is the in-depth experiences participants shared. The qualitative design, which included open-ended questions, allowed participants to recall and describe their lived experience in detail, which permitted a deeper understanding of their personal experience. Participants' years of experience within social work, which included hospital social work, further allowed for a wide range of experiences to be shared. In addition, a deeper insight as to how the experiences have impacted their lives and work over multiple years was detailed. Participants' experience in various settings of the health care system further allowed for various and unique experiences to be

shared and heard. Finally, in-depth interviews strengthen the study by allowing the ability to reveal participants' thoughts, feelings, experiences and perceptions.

There are, however, several limitations to the study. The first limitation involves the participants all being current hospital social workers. By limiting the study to hospital social workers that have successfully coped with critical incidents, the study lacks the experience and perception of individuals who have left the field, perhaps due to the stress and inability to cope with critical incidents. In essence, only the participants who have survived this issue over time are studied in this research.

Second, the sample size was small. Of 50 identified possible participants, only seven responded with an interest to participate. Additionally, all participants were female and therefore, experiences and coping may be influenced by gender, and therefore differences must be taken into account.

Furthermore, all participants work within the same health care system, which poses a limitation due to the possibility of different health care systems enforcing dissimilar policies and procedures. Likewise, hospital social workers may have different experiences based on the system in which they work. Similar to various health care systems, various settings and units within a health care system may operate under different policies and procedures, which may also allow for differing experiences of social workers. As over half the participants in this study are from the hospice setting, a limitation arises in that unique experiences of hospice may overshadow and skew the experiences of hospital social workers from other settings and units.

Implication for Social Work Practice and Policy

Hospital social workers work with clients in distress caused by mental illness, terminal illness or traumatic events. These highly emotional interactions, routinely experienced, have the ability to cause stress reactions such as compassion fatigue, burnout and posttraumatic stress disorder. Yet not all hospital social workers succumb to the stress of experienced critical incidents. Rather, some effectively cope with the experiences and grow personally and professionally. Findings from this study include seven hospital social workers experience with critical incidents along with successful coping techniques. Additionally, the experiences served to provide a personal and professional growth for the social worker. Therefore, these findings can increase the awareness of critical incident stress experienced by hospital social workers as well as successful coping techniques by understanding successful techniques these participants have employed in order to cope with critical incident experiences. Further, in response to successful coping techniques of participants, possible policy changes or programs that respond to critical incidents may be suggested.

Of the coping techniques defined, support of peers and colleagues was reported by all participants and therefore suggests the need for staff development and strengthening of relationships among colleagues. While literature surrounding stress and coping primarily promote formal programs and debriefings, participants more often reported the need for informal and immediate processing opportunities. In addition to staff development and relationship

strengthening, by creating an atmosphere conducive to colleague support and the acceptance of acknowledging emotional reactions with caring, understanding peers, critical incidents may be coped with rather than suppressed or denied.

A balance in life and self-care was also a prominent coping technique, suggesting the need for hospital social workers to have adequate time outside of work. Encouraging and supporting mental health days and vacation opportunities can assist in this coping technique. Additionally, by providing social opportunities, social workers will not only have the ability to be involved in activities outside the work place but may also build relationships with colleagues.

Educational opportunities can also aid in the ability of coping with critical incidents. Further, education may be based on work-related issues as well as self-care topics, such as stress management.

Finally, participants indicated the need to feel fit to their role within the hospital. Therefore, it can be suggested that a worker be allowed, when possible, to transfer units when it is determined that the current role or unit is not a complementary role. Ideally, a worker would have the opportunity to experience and explore the various units prior to permanent assignment to a role.

Implication for Further Research

Participants of this study reported a personal and professional growth due to the experience of critical incidents. For this reason, these participants may have been more willing to participate. Therefore, research could be done involving participants no longer employed as a hospital social worker in order to understand their lived experience. Through this, an understanding may be gained

as to situations that did not allow successful coping. Likewise, a study involving a larger number of participants may allow for greater and more diverse experiences and a deeper understanding of the experiences of hospital social workers.

Further research may also include participants from various health care systems in order to determine differing experiences based on diverse hospital policies and procedures. Equally, a comparison study may be conducted to find differing experiences, if any, between various settings within a health care system. Finally, as participants reported growth due to critical incidents and specific ways in which they coped with stress, further research may be conducted in order to compare a variety of coping techniques.

Summary

Literature surrounding stress of social work, specifically hospital social work, verifies the highly traumatic nature of the occupation. Similarly, current literature addresses negative stress reactions that may occur due to experiences of critical incidents as well as literature surrounding diverse coping techniques. However, little research has been done on the positive impact critical incident experiences can have on hospital social workers. Additionally, current literature ignores specific coping techniques successfully in place by hospital social workers. This research explores the lived experience of seven hospital social workers relating to stress and coping with critical incidents. Findings of this study include that not only can hospital social workers successfully cope with critical incidents but also, more importantly; these experiences can assist in the

social worker's professional, personal and spiritual growth.

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Appendix A

Letter of Introduction

Letter of Introduction

Hi, my name is Amy Hertle. I am working at St. Josephs Hospital in an internship position with Social Work Services, which fulfills a partial requirement in the process of obtaining a Master's degree in Social Work at Augsburg College. I am also conducting a research study for a final thesis requirement. For my thesis, I have chosen to study the experience of hospital social workers in regards to stress and coping with critical incidents. The Institutional Review Board at Augsburg College has approved this study (IRB #99-72-3).

While there is research and literature on the stress of social work and also on various coping methods used by people who experience critical incidents, the purpose of this study is to hear about personal experiences from hospital social workers themselves in order to gain and give readers a deeper understanding of lived experiences of hospital social workers surrounding stress and coping with critical incidents.

Participant's confidentiality will be protected. No names or identifiable information about participants will be used in this study.

Indirect benefits of the study may include improving the understanding of social work practitioners, as well as the researcher, regarding lived experiences with stress and coping with critical incidents. Participants may also find it beneficial to have an opportunity to reflect and share personal experiences.

The study also has a minimal risk if you choose to participate. During the interview you will be asked to recall particularly difficult experiences that may have been highly emotional for you. Recalling the experience may elicit normal, but strong, emotional reactions. Should this occur, you may choose to withdraw from the study at any time with no consequences. Additionally, if overwhelming discomfort occurs due to the interview questions, a phone number will be provided for crisis intervention.

Participation is voluntary and confidential. The process would involve a 45-60 minute, in-person interview in which I would ask you a few questions. With permission I would like to audiotape the interview for transcription purposes. All audiotapes and transcripts will be destroyed for confidentiality purposes prior to August 31, 2000. Only the researcher and thesis advisor will have access to tapes and transcripts.

If this is something that you would be interested in participating in please contact me at (651) 232-6311 in order to determine a time that is convenient for an interview. If this does not interest you, thank you for your time.

Or if you need further information, you may contact my thesis advisor: Maria Dinis, Ph.D., Business Phone: (612) 330-1704

Thank you,

Amy Hertle

Appendix B

Participant Consent Form

The Experience and Coping of Hospital Social Workers with Critical Incidents

Consent Form

You are invited to participate in a research study designed to look at the lived experience of hospital social workers involved with critical incidents. Participation is completely voluntary. The researcher is an intern at St. Johns Hospital and is conducting the study as part of a thesis requirement for the Masters in Social Work Program at Augsburg College. You have been identified as a possible candidate for participation as you have experience with hospital social workers and critical incidents. Please read this consent form and ask any questions prior to agreeing to participate in the study.

Study Purpose

The purpose of the study is to hear about personal experiences from hospital social workers themselves in order to gain and give readers a deeper understanding of lived experiences of hospital social workers surrounding stress and coping with critical incidents.

Study Procedure

The study consists of one 45-60 minute interview, which will be audio taped with your permission. You will be asked to relate experiences you have had with critical incidents experienced while working as a hospital social worker. Once the interview has been interpreted, you may be asked to review and verify the interpretation to reflect your experience.

Risks and Benefits

Indirect benefits of the study may include improving the understanding of social work practitioners, as well as the researcher, regarding lived experiences with stress and coping with critical incidents. Participants may also find it beneficial to have an opportunity to reflect and share personal experiences.

The study also has a minimal risk if you choose to participate. During the interview you will be asked to recall particularly difficult experiences that may have been highly emotional for you. Recalling the experience may elicit normal, but strong, emotional reactions. Should this occur, you may choose to withdraw from the study at any time with no consequences. Additionally, if overwhelming discomfort occurs due to the interview questions, participants will be provided with the phone number for Minneapolis Crisis Intervention at 612-347-3161.

Confidentiality

Records of this study will be kept confidential. Audio taped interviews and transcriptions will be kept in a locked drawer and will be destroyed prior to August 31, 2000. The researcher and thesis advisor will be the only people to have access to the material. Any identifying information from the interview will

be altered or removed to ensure privacy. Because of the small sample size, I cannot guarantee that someone may not recognize your story. No names or identifiable information about participants will be used in the study.

Voluntary Participation

Your decision to participate is completely voluntary. If at any time you decide to not participate, you may withdraw with no consequences.

Questions/Contacts

The researcher conducting the study is Amy Hertle. If you have any questions please contact the researcher at (651) 232-6311. Questions and concerns may also be directed to Maria Dinis, Thesis advisor, Augsburg College, (612) 330-1764.

Consent Statement

Before you sign this form please be sure to have any questions regarding this study answered. I will attempt to answer any question that arises, prior, during or following the study.

AUTHORIZATION: I,_____, have read this consent form and decide to participate in the research project described above. My signature indicates that I give permission for information I provide in the interview to be used for a thesis research project.

Signature_____

Date_____

In addition: I give permission to be audio taped.

Signature _____ Date_____

I give permission to the use of direct quotes from my interview.

Signature _____ Date_____

Appendix C

Interview Questions

Interview Questions
To be asked by the researcher

Research study questions: 1) what is the lived experience of hospital social workers relating to Critical Incident Stress? 2) How do hospital social workers cope with the impact of stressful events?

1) Can you define what is a critical incident for you?
2) Tell me about two critical incidents you have experienced?
3) Based on your definition of a critical incident, how did each experience impact you?
4) How did you cope with each experience?
5) How did your personality change, if at all, due to the experience?
6) How has your work changed since these critical incidents?

Prompts:
1) Tell me more about that.
2) Can you clarify that?
3) Tell me a time that comes to mind to you that evokes memories of the incident?
4) What does it mean to you?
5) What was it like for you to have had this experience?
6) For instance?

Appendix D

Confidentiality Form

CONFIDENTIALITY FORM

This research study includes sensitive and confidential information about study participants. This information is shared with you confidentially for the purpose of being transcribed. By signing this form you are agreeing to not reveal names, identifying information or any off the content of the interviews.

_____

Name of Transcriptionist

_____

_____

Signature Date

Appendix E

IRB Application and Approval Letter

AUGSBURG

C • O • L • L • E • G • E

MEMO

January 27, 2000

To: Ms. Amy B. Hertle

From: Dr. Sharon Patten, IRB Chair SKP
Phone: 612-330-1723

RE: Your IRB Application

Thank you for your response to IRB issues and questions. Your study, "Hospital Social Workers: A Qualitative Study of the Experience and Coping with Critical Incidents," is approved; your IRB approval number is 99-72-3. Please use this number on all official correspondence and written materials relative to your study.

Your research should prove valuable and provide important insight into an issue in social work practice, planning, and policy. We wish you every success!

SKP:ka

cc: Dr. Maria Dinis, Thesis Advisor

DEPARTMENT OF SOCIAL WORK

AUGSBURG

C • O • L • L • E • G • E

MEMORANDUM

To: Amy Beth Hertle
From: Sharon K. Patten, Ph.D. (330-1723) SKP
RE: Your Recent IRB Application
Date: January 10, 2000

I am writing on behalf of the College's Institutional Review Board on the Use of Human Subjects to outline for you our concerns regarding your proposed study, "Hospital Social Workers: A Qualitative Study of the Experience and Coping with Critical Incidents". At our recent meeting, your application was approved with the following conditions. These conditions must be satisfied and approved by the chair before final approval of your research and before you can initiate contact with research participants:

Condition 1: On the consent form under "Risks and Benefits" specify the name and telephone number for crisis intervention.

Condition 2: On the consent form under "Confidentiality" delete the second to last sentence and replace it with: Because of the small sample size, I cannot guarantee that someone may not recognize your story.

Also, the Committee has one suggestion regarding the interview questions. Question #6 would be more useful if clarified (for example, how has your work changed since these critical incidents?)

Please carefully consider our comments and discuss your next steps with your advisor. After making the necessary changes, please submit your changes to Dr. Ferrell addressing these issues, and specifying your changes. The letter to Dr. Ferrell should be sent to: Lois M. Nielsen, Associate, Academic and Learning Services, Campus Box 136, at Augsburg College. Note on the envelope that it is to the attention of Dr. Ferrell. As stated above, you are not authorized to begin work on your research until final review is completed and an IRB approval number is assigned.

The Institutional Review Board wishes you the best in your research.

cc: Lucie Ferrell, R.N., Ph.D., Chair, IRB
Maria Dinis, Ph.D., Thesis Advisor

DEPARTMENT OF SOCIAL WORK
Campus Box #51 • 2211 Riverside Avenue • Minneapolis MN 55454 • Tel. (612)330-1189 • Fax (612)330-1493

Augsburg College Institutional Review Board

REQUEST FOR APPROVAL FOR THE USE OF HUMAN SUBJECTS IN RESEARCH
Social and Behavioral Sciences

1. **Project Title**: (use same title as grant application, if applicable)

Hospital Social Workers: A Qualitative Study of the Experience and Coping with Critical Incidents.

2. **Principal Investigator** Amy Beth Hertle MSW
(first mi last degree)

Telephone number (651) 429-3270

College department name Social Work Graduate Department

Investigators address 5155 St. Anthony Ave
White Bear Lake, MN 55110

Campus Box _____

(For IRB Use Only)

Approval # _____

IRB Chair: _____
(Signature)

3. **Check one**:
_____ Faculty / staff research
_____ Fellow / post doctoral
_X_ Student Research
_____ Undergraduate
_X_ Graduate

4. **If principal investigator is a student:**
Advisor's Name: Maria Dinis
Address: Augsburg College
Minneapolis, MN 55454
Telephone (612) 330-1704

5. Applications for approval to use human subjects in research require the following assurances and signatures to certify:

- The information provided in this application form is correct.
- The Principal Investigator (PI) will seek and obtain prior written approval from the IRB for any substantive modification in the proposal, including, but not limited to changes in cooperating investigators, agencies as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study will be promptly reported.
- Any significant new findings which develop during the course of this study which may affect the risks and benefits to participation will be reported in writing to the IRB and to the subjects.
- The research may not be initiated until final written approval is granted.

This research, once approved, is subject to continuing review and approval by the IRB. The PI will maintain records of this research according to IRB guidelines.

If these conditions are not met, approval of this research could be suspended.

Signature of Principal Investigator Amy Hertle Date 12-30-99

Student Research: As academic advisor to the student investigator, I assume responsibility for insuring that the student complies with College and federal regulations regarding the use of human subjects in research:

Signature of Academic/Thesis Advisor Maria Dinis Date _____

Faculty/Staff Research: As department chair, or designed, I acknowledge that this research is in keeping with the standards set by our department and assure that the principal investigator has met all departmental requirements for review and approval of this research.

Signature of Department Chair _____ Date _____

6. Checklist for Investigators
(application will be returned if not complete)

_X_ (1) This application includes a lay abstract stating the purpose of the study.

_X_ (2) The application describes the study population, inclusion/exclusion criteria, process of identifying subjects, etc.

_X_ (3) The abstract includes a description of tasks the subjects will be asked to complete.

_X_ (4) The application includes a full description of anticipated risks and benefits of study participation.

_X_ (5) Provisions have been made to minimize risks and those procedures are outlined on the form.

_X_ (6) Provisions have been made and documented to care for subjects in case of accident or injury.

_X_ (7) Procedures to maintain confidentiality have been fully described.

_X_ (8) Provisions have been made to obtain informed consent from all individuals related to the study. (e.g., parents, subjects, cooperating institutions, etc.)

_X_ (9) All questions on the form have been completed.

_X_ (10) All supporting documents have been attached, including protocol, survey instruments, interview schedules, solicitation letters, advertisements, consent forms, etc. **Supporting documents must be in final form as you intend to distribute them. Your application will be returned if these documents are in outline or first draft form.**

_X_ (11) If this study requires approval of another committee or cooperating agency, documentation of approval or notice of application has been attached.

_X_ (12) Appropriate departmental signatures and signature of academic advisor for student research have been obtained on Page 1.

_X_ (13) A copy of this application has been made for the investigator's records.

___ (14) I request blind review. I have omitted all identifiers from copies submitted. (Original copy contains all names for IRB file.)

_X_ (15) The application is in the same page format as shown in this electronic word processing file. The location of questions and pagination is the same as in the original.

_X_ (16) I attach 15 copies for full review applications **or** three copies for expedited applications **or** two copies for exempt applications, including any attached instruments and materials.

You must make a preliminary judgment about the level of review required for your application. The chair will then determine the level of review after submission and contact you if additional copies are required.

Completed, *typewritten* forms should be returned to:

Lucie Ferrell, PhD, Chair
Augsburg College Institutional Review Board
Augsburg College, 2211 Riverside Avenue, Campus Mail #111
Minneapolis, MN 55454-1351
(612) 330-1215

7. **Project title** Hospital Social Workers: A Qualitative Study of the Experience and Coping with Critical Incidents.

Inclusive dates of project: December 1, 1999 to August 31, 2000.

8. **Project** (please circle): **has been / will be submitted to the following funding agency**:
N/A

Funding decision (please circle): **is pending / has been awarded**.

Agency-assigned grant number (if known): _____

If this study is part of a program or center grant, provide the title and principal investigator:
MSW

9. **Is this research subject to review by another internal committee of the College?**
_X_ No ___ Yes: If yes, attach documentation of approval.

Specify:_____

10. **Is this research conducted at another location or with a cooperating organization, e.g., schools, clinics, community agencies, etc.?**
_X_ No ___ Yes: If yes, provide written documentation of approval from that institution.

Specify:_____

CHECK REVIEW CATEGORY BELOW:

11. **_X_** This research requires **full review** by the Institutional Review Board.

12. ___ **Expedited Review** (see Application Information on page ii): This research fits the precise requirements of category _____of the expedited review provision of 45 CFR 46.110." The research could be considered of "minimal risk" to participants based on those guidelines.

13. ___ **Exemption category**: (See Application Information on pages iii and iv.): This research fits the precise requirements of category _____ of the exemption categories of 45 CFR 46.101(b).

Exempt applications only categories 4-6:

Exempt Category #4: Pathological Specimens
All pathological specimens should be stripped of identifiable information prior to use. Describe the source of the specimens. How will they be obtained? If not obtained by the principle investigator, then by whom?

Exempt Category #5: Public Service programs
In addition to the information provided under *abstract*, above, provide documentation or cooperation from the public agency involved in the research.

Exempt Category #6: Taste Testing
Food ingredients must be at or below the levels found to be safe by federal regulatory agencies. Describe the food to be tested and provide assurance that these conditions are met.

14. **Lay Summary**

Describe your research project using lay language--language understood by a person unfamiliar with the area of research. Include your research question and methods to be used (hypothesis and methodology). Provide the justification for the research (what is the need or problem being addressed by the study, why this research should be done). Describe in detail the tasks subjects will be asked to complete/what subjects will be asked to do

This research is a qualitative study to find out what is the lived experience of hospital social workers relating to critical incidents and coping with such events. The research questions are: 1) What is the experience of hospital social workers relating to critical incident stress? and 2) How do hospital social workers cope with the impact of stressful events?

Participants will include hospital social workers with a minimum of three years experience in addition to experience of working in critical care settings and have been exposed to critical incidents. The study sample will be gathered through a non-probability, purposeful sampling where possible participants meeting the criteria will be identified by a professional in the field of hospital social work. Once identified, potential participants will be given a letter of introduction, found in attached Appendix A. The first ten people to respond to the letter will be contacted to be participants. After reviewing and signing a consent form, found in attached Appendix B, a date and time will be established for an interview.

The study will include an in-depth, semi-structured interview format, lasting 45-60 minutes, which will be audio taped, with participant permission, for transcription purposes. The interview will consist of open-ended questions found in attached Appendix C. Once information is gathered a transcriptionist who has signed a confidentiality form will transcribe the audiotapes. Transcriptions will then be interpreted to discover common meanings and themes.

While there is research and literature on the stress of social work and also on various coping methods used by people who experience critical incidents, the purpose of this study is to hear about personal experiences from hospital social workers themselves in order to gain and give the researcher as well as readers a deeper understanding of lived experiences of hospital social work surrounding stress and coping with critical incidents.

15. **Subject Population**

a. Number: Male __ Female _Total **10**

b. Age Range: **25 +**

c. Location of Subjects:
(Check all that apply)

____ elementary / secondary schools
____ outpatients
____ hospitals and clinics
____ college students
____ other special institutions: specify: _Family service agencies/social service agencies
____ other: specify: _____

d. Special Characteristics:
(Check all that apply)

____ children
____ inpatients
____ prisons/halfway houses
____ patient controls
__X__ adult volunteers

e. If research is conducted off-campus, written documentation of approval/cooperation from that outside agency (school, clinic, etc.) should accompany this application. Be sure all levels with this authority within the agency/organization have given approval.

N/A

f. Describe how subjects will be identified or recruited. Attach recruitment information, i.e., advertisements, bulletin board notices, recruitment letters, etc.

I will begin a purposeful sample by talking with a professional in the field of hospital social work regarding my research topic. Through this process several potential participants will be identified (at least 10).

g. If subjects are chosen from records, indicate who gave approval for the use of the records. If these are private medical recording agency records, or student records, provide the protocol for securing consent of the subjects of the records and approval from the custodian of the records.

N/A

h. Who will make the initial contact with the subject? Describe how contact is made. **If recruitment is verbal, provide the script to be used.**

I will talk with a professional in the field of hospital social work about my study and ask him to refer prospective participants. I will ask the professional to give the prospective participants a letter of introduction in which they will be asked to call me if they are interested in participating in my study. Attached is the letter of introduction (Appendix A).

i. Will subjects receive inducements before, or rewards after the study? If yes, explain how and when they will be distributed.

N/A

j. If subjects are school children, and class time is used to collect data, describe in detail the activity planned for non-participants. Who will supervise those children? (This information should be included in the consent form.)

N/A

16. **Risks to participation**: (check all that apply)

____ use of private records (medical, agency or educational records);
_X_ possible invasion of privacy of subject or family;
____ manipulation of psychological or social variables such as sensory deprivation, social isolation, psychological stresses;
_X_ any probing for personal or sensitive information in surveys or interviews;
____ use of deception as part of experimental protocol; the protocol must include a "debriefing procedure" which will be followed upon completion of the study, or withdrawal of the subjects. Provide this protocol for IRB review;
____ presentation of materials which subjects might consider offensive, threatening, or degrading;
____ other risks: specify: _____

Describe the precautions taken to minimize risks:

Participants will be informed that if they feel overwhelming discomfort at any time during the interview, they are encouraged to stop participating in the study without consequence. They will be given referral information to counselors regardless of whether they report any emotional or psychological discomfort.

17. **Benefits to participation**:

List any anticipated direct benefits (money, or other incentives) to participation in this research project. If none, state that fact here and in the consent form. Also, list indirect benefits to participation (e.g., improved programs or policies; contribution to knowledge)

Indirect benefits of the study may include improving the understanding of social work practitioners, as well as the researcher, regarding lived experiences of hospital social workers regarding stress and coping with critical incidents. Participants may find a benefit in providing information to allow for this understanding. Participants may also find it beneficial to have an opportunity to reflect and share personal experiences.

18. **Confidentiality of Data:** (note that the consent forms should include this information.)

A. Describe provisions made to maintain confidentiality of data.

Records of this study will be kept confidential. Audio taped interviews and transcriptions will be kept in a locked drawer and will be destroyed prior to August 31, 2000. The researcher and thesis advisor will be the only people to have access to the material. Any identifying information from the interview will be altered or removed to ensure privacy. All information will be kept confidential but not anonymous. No names or identifiable information about participants will be used in the study.

B. How will you disseminate results or findings? Who will receive copies of results and in what form?

The results from my study will be presented in my thesis paper as well as shared with my advisor and thesis readers.

C. Where will the raw data be kept and for how long?

Raw data will be kept in my home in a locked desk until no later than August 31, 2000.

Give the date for destruction of raw data. If raw data is retained, give date when identifiers will be removed. August 31, 2000

(If tape recordings or videotapes are created, explain who will have access and how long the tapes will be retained.)

Raw data including audiotapes will be destroyed no later than August 31, 2000. Only the researcher, the transcriptionist and the thesis advisor will have access to the audiotapes until no later than August 31, 2000.

D. What security provisions will be used? Who will have access to the collected data?

I will keep all audiotapes and notes in a locked desk in my home without identifiers. The only people who will have access to the collected data will be the researcher, the transcriptionist and the thesis advisor.

E. Will data identifying the subjects be made available to anyone other than the principal investigator, e.g., school officials, etc.?

X_ No ___Yes: If yes, explain below and in the consent form.

F. Will the data be part of the subject's chart or other permanent record?

X_ No ___Yes: If yes, explain.

G. Do you request a College box be assigned to you for the return of surveys?

_**X**_ No __Yes I need a voicemail # as a means to contact with my participants.

19. **Informed consent process**: Prepare and attach a consent form or a consent letter:

A consent form is required for research involving risk, and for research where permanent record of results are retained (including videotapes). Signatures of subject (and parent) are required.

A consent statement or letter to participant(s) may be used in surveys but does not require the signature of the subject. Provide text of consent statements read to study subjects, distributed to participants prior to interviews or used as a cover sheet for a written survey.

The following questions pertain to the consenting process (also see sample consent form, pp. vii-viii).

A. Describe what will be said to the subjects to explain the research. (Do not say "see consent form"; write the explanation in lay language.)

I will begin by introducing myself and explaining the reason I am conducting this study. I will say to the prospective participant, "I am interested in understanding the experience of hospital social workers relating to the experience of critical incidents and coping with such events, and I am very interested in hearing your story. I would like to find out what experiences stand out for you, and to hear what it has been like for you to go through the process. For my study, I will be interviewing ten social workers with hospital experience. After the interviews are complete, I will take the stories and compare them to see any common experiences, themes, or meanings."

At this point I will ask the participant if they have any questions and if what I have said is clear. I will then explain the consent form to them. Together we will read the form and I will again ask if there are any questions. I will explain that the interview will take approximately 60 minutes during which time I will ask about their experiences as a hospital social worker experiencing critical incidents. I will explain that their name and all information will be kept confidential, but that it is not possible to ensure complete anonymity. If they do not understand the differences between anonymity and confidentiality, I will clarify that, because of the small sample size, I cannot guarantee that someone may not recognize their story (i.e. anonymity). However, I will reassure them that I will take all steps possible to conceal their identity. I will also tell them that the data will be kept in a locked desk only to be seen by the transcriptionist, my thesis advisor and myself. I will add that when my thesis is complete, I will destroy the audiotapes and papers to maintain confidentiality. At this time, I will ask if they have any other questions.

I will then tell them that their participation in this study is completely voluntary and ask her if they would be interested in participating. If their answer is yes, I will ask them to sign the consent and ask for permission to audiotape the interview for transcription purposes. We will then set a time for an interview.

B. What questions will be asked to assess the participant's understanding?

The participants will be asked if they have any questions regarding the study, confidentiality of the study, or the consent form. If they have any questions, the researcher will be available to answer questions. If requested, they may call the researcher's thesis advisor as well.

C. In relation to the actual data gathering, when will consent be obtained?

Consent will be obtained before the interviews are conducted.

D. Will the investigator(s) be securing all of the informed consent? _**X**_ Yes _____ No: If no, name the specific individuals who will obtain informed consent.