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## **MAKING THE CONNECTION: USING SOCIAL CONSTRUCTIVIST THEORY TO EXAMINE DIALYSIS SOCIAL WORKERS'**

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# MAKING THE CONNECTION: USING SOCIAL CONSTRUCTIVIST THEORY TO EXAMINE DIALYSIS SOCIAL WORKERS'

## Abstract

ABSTRACT

MAKING THE CONNECTION: USING SOCIAL CONSTRUCTIVIST THEORY TO EXAMINE DIALYSIS SOCIAL WORKERS'

PERCEPTIONS OF STRESS

Charisse Eudella Marshall, LCSW

Richard Gelles, Ph.D

Lani Nelson-Zlupko, Ph.D., LCSW

Work-related stress is a significant aspect of clinical work and case management. To date, there are few studies available that explore this professional phenomenon in dialysis social work practice. Since dialysis social work is the only genre of social services that is federally mandated, there needs to be more exploration of the professional stressors that may influence the effectiveness of clinical social work. Informed by a thorough literature review, a sample of 12 (N=12) Licensed Master's Level Social Workers based in New York and Pennsylvania were recruited using various forms of social media and snowball sampling to explore work-related stress in dialysis social work practice. Participants were asked a series of questions regarding their perceptions of stress, coping skills and overall, how they individually handle stress at work. During the interview process, participants described specific experiences with stress on dialysis units that were consistent with current literature. The 12 semi-structured interviews were coded, transcribed, and then textually analyzed using the MAXQDA 11 (1989) professional software for qualitative analysis. Two specific themes emerged from the study: job flexibility and work commitment. The theoretical underpinnings of Social Constructivist Theory were used to explore the common themes uncovered in Chapter 5: Findings. The Social Constructivist Theory ( Dewey, 1933; Vygotsky, 1934; Piaget, 1972; Bruner 1990) suggests that groups and/or communities tend to share values and traits as well as actions. The findings provide insight into the homogeneous perceptions of stress in dialysis social work practice.

## Degree Type

Dissertation

## Degree Name

Doctor of Social Work (DSW)

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**Keywords**

social constructivist theory, perceptions of stress, dialysis social work

**Subject Categories**

Social and Behavioral Sciences | Social Work

MAKING THE CONNECTION: USING SOCIAL CONSTRUCTIVIST  
THEORY TO EXAMINE DIALYSIS SOCIAL WORKERS'  
PERCEPTIONS OF STRESS

CHARISSE EUDELLA MARSHALL

A DISSERTATION

in

SOCIAL WORK

Presented to the Faculties of the University of Pennsylvania

in

Partial Fulfillment of the Requirements for the

Degree of Doctor of Social Work

2015

Supervisor of Dissertation

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MAKING THE CONNECTION: USING SOCIAL CONSTRUCTIVIST THEORY  
TO EXAMINE DIALYSIS SOCIAL WORKERS' PERCEPTIONS OF STRESS

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## **Dedication**

I would like to dedicate this dissertation to the late Mrs. Doris Agnatha Jordan Marshall (my mother) and late Mr. Elridge John Worrell Marshall (my father). Doris and Elridge worked tirelessly to give their five children the gifts of love and educational access. I would also like to recognize my siblings Delsia, Cynthia, Meredith, and Wendy, and in-laws Ted and Yolonda for their undying support of this educational endeavor. I hope that this publication inspires my niece Nya and nephews Masai, Cameron, Kobe, and Chase to change the world.

## ACKNOWLEDGMENTS

I want to thank all who supported me throughout this journey. Special thanks to Professor Richard Gelles of the University of Pennsylvania–School of Social Policy & Practice, who served as my First Reader, mentor, and guide throughout this endeavor. A special thanks to the dissertation committee and university faculty members, including Program Director, Dr. Lina Hartocolis and Program Coordinators, Ms. Angel Hogan and Mr. Jeff Curry, for their support. A sincere word of thanks to both the Departments of Social Work and Emergency Medicine of The State University of New York–Downstate Medical Center: namely administrators Mr. Barry Mandel, LCSW, Dr. Roger P. Holt, and Mr. Charles Pryde for their mentorship. I also wish to thank the members of Tau Omega Chapter of Alpha Kappa Alpha Sorority, Incorporated. A “heart-felt thank-you” to both Dr. Lani Nelson-Zlupko who served as the Supervisor of Dissertation and Dr. Alexandra Duncan who served as Third Reader. Thank you to Dr. Michelle Kondo for serving as my interim advisor and tutor. To all of my cohort mates, thank you for inspiring me. To Mery Diaz, William Felder, Kimberly Cohens, Nicole McElroy, and Sabrina Gonzalez, thank you for your kindness while I commuted back and forth to campus.

## **ABSTRACT**

# **MAKING THE CONNECTION: USING SOCIAL CONSTRUCTIVIST THEORY TO EXAMINE DIALYSIS SOCIAL WORKERS' PERCEPTIONS OF STRESS**

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Social Constructivist Theory ( Dewey, 1933; Vygotsky, 1934; Piaget, 1972; Bruner 1990) suggests that groups and/or communities tend to share values and traits as well as actions. The findings provide insight into the homogeneous perceptions of stress in dialysis social work practice.

## TABLE OF CONTENTS

ABSTRACT.....	v
LIST OF TABLES.....	
LIST OF ILLUSTRATIONS.....	
CHAPTER 1: INTRODUCTION.....	1
What is Dialysis Social Work?.....	2
Background of the Problem.....	3
Purpose of Study.....	5
Research Question(s).....	6
Importance of the Study.....	6
Study Limitations.....	7
CHAPTER 2: LITERATURE REVIEW.....	9
The Evolution of Dialysis Social Work.....	9
The Medical Aspect of Work: Kidney Disease and Dialysis Treatment.....	11
Hemodialysis.....	13
Peritoneal Dialysis.....	14
Issues with Hemodialysis and Peritoneal Dialysis Treatment Use.....	15
The Mandated Implementation of the KDQOL-36 (1994; 2000).....	16
The Challenges of Using the KDQOL-36.....	17
Work-Related Stress and the Perception Thereof.....	19
The Role of Patient Non-compliance in Work-Related Stress.....	22
Social Constructivist Theory and Dialysis Social Work.....	25
Stressors in Dialysis Units.....	32
Patient Acuity Level as a Professional Stressor.....	32
Social Issues Among Colleagues and Other Professionals.....	33
Emotional Factors of Work-Related Stress.....	35
Organizational Stress Factors.....	36
Supervision.....	39
Gaps in Current Literature.....	40
CHAPTER 3: METHODOLOGY.....	42
Purpose of Study.....	42
Research Question(s).....	42
Subject Population and Recruitment.....	42
Inclusion Criteria.....	43
Human Subject Protection.....	44
Incentives.....	45
Data Collection.....	45
Data Analysis.....	47
Reflexivity Statement.....	48
Risks and Benefits of Subject Participation.....	48
CHAPTER 4: FINDINGS.....	49
Description of Sample.....	49
Job Flexibility.....	52
Work Commitment.....	52
Other Significant Findings.....	55

Paperwork and Administering the KDQOL-36 .....	55
When Support Is Not Enough .....	58
Client Death as a Stressor .....	59
Difficult Patients as a Stressor .....	61
Sense of Entitlement .....	63
Patients in Denial .....	64
Lack of Professional Respect.....	65
Threatening to Quit .....	66
Situational Stressors.....	68
Hurricane Sandy.....	68
Policy-Budget Sequestration 2013.....	69
CHAPTER 5: CONCLUSION, DISCUSSION, AND AREAS FOR FUTURE	
RESEARCH.....	72
My Observations .....	73
Bias/Limitations .....	76
Implications for Future Practice and Conclusion.....	77
APPENDICES .....	79
Appendix A Proposed Semi-Structured Interview Guide.....	79
Appendix B Consent Form for Qualitative Semi-Structured Interview.....	83
Appendix C Clinical DSW Dissertation Qualitative Interview Field Notes.....	85
REFERENCES .....	107

## LIST OF TABLES

Table 1. Demographics of subjects 1-12 N=12 .....	50
Table 2. Descriptive Demographics of Sample N=12 .....	51

## LIST OF ILLUSTRATIONS

Figure 1. Illustration of the Influence of Non-compliance as a Stressor in the Therapeutic Alliance .....	22
Figure 2. Influence of Social Constructs and Stressors on the Clinical Relationship between Dialysand and Social Workers .....	28

## CHAPTER 1: INTRODUCTION

On October 2, 2012, the Turner Cable News Network (CNN) featured a segment on “The Career Project,” an interactive research database that cited social work as the number one “Most Stressful Job that Paid Badly.” The project revealed that 72% of the social workers polled felt that their jobs were stressful (CNN, 2012). The citation also mentioned that social work positions are stressful because “social workers step in when everyone else steps aside,” specifically when working with vulnerable populations (CNN, 2012).

Although stress is a common occurrence among social workers, it may be understood, perceived, and managed differently within the professional group. Dialysis social workers were selected as the subject for this study due to the unique conditions of their work (i.e., federal mandates, high-risk clientele, chronic disease, and socioeconomic pressures). This research study uncovered a distinct type of stress specifically known to dialysis social workers due to the physical and social issues experienced through their relationships with their clients. According to Beder (1999), “psychosocial stresses are a fixed feature of the lives of dialysis patients” (p. 17).

The dialysis care is a stressful setting with complex medical technology and chronically infirmed patients (Jones, 2014) that makes dialysis work an interesting breeding ground for new research on work-related stress. In relation to social work practice, there is a small body of literature examining the parallels between dialysis social work and stress. This qualitative study explores the work experiences of 12 social workers recruited from the states of New York and Pennsylvania with varying levels of

professional work experience post-Masters of Social Work (MSW) degree training, ranging from six months to 30 years.

The findings of this study are consistent with current literature, which emphasized high workloads, paperwork, and the importance of supportive relationships to counterbalance stress. Based on the information provided from these interviews, job turnover does not appear to be a significant theme in dialysis social work as it is in other genres of social work practice such as Child Welfare (DePanfilis & Zlotnik, 2008; Landsman, 2001; Mor Barak et al., 2006; Mor Barak et al., 2005; Mor Barak, Nissly, & Levin, 2001; Strolin et al., 2007; Yankeelov et al., 2009; Zlotnik et al., 2005). The high level of professional commitment evolved as a theme and appears to also lend to other professional trends such as job longevity and professional fortitude.

### **What is Dialysis Social Work?**

As an experiment in 1905, Dr. Richard Cabot of Massachusetts General Hospital introduced the first social worker into the milieu of the medical setting (Fortner-Frazier, 1981; Gregorian, 2005; Kitchen & Brook, 2003). Ida Cannon served as the founder of the first department of social work at Massachusetts General Hospital (Bilchik, 1999). Her work affirmed that medical social work practice represented the "social conscience" of the medical facility in caring for patients (O'Donnell et al., 2008). The experiment was a success and social workers earned a permanent role on the interdisciplinary team to provide patient counseling, support, and discharge planning services.

Social work practice in health settings requires competency in five areas: human behavior and the social environment, social welfare policy and services, social work practice, research, and field practicum (Council on Social Work Education, 1982; Henk,

1989). Since the late 1970s, social workers have evolved to become a mandated and required member of the interdisciplinary teams that provide comprehensive care and services to dialysis patients (DHHSCMMS 42 CFR Parts 405, 482, 488, and 498, 1976; Beder, 2008). As per the National Association of Social Workers:

*Nephrology social work services support and maximize the psychosocial functioning and adjustment to chronic kidney disease for patients and their families. These services are provided to improve social and emotional stresses, which result from the physical, social, and psychological concomitants of chronic kidney disease. Nephrology social workers are a part of an interdisciplinary team; they collaborate with other team members to help them in understanding the biopsychosocial factors which can have an impact on the treatment course (Council of Nephrology Social Workers, 2002, p.8).*

### **Background of the Problem**

Since 1976, and guided by Medicare mandates, dialysis clinics have employed master's level trained social workers to respond to the diverse psychosocial needs of the population (Prescott, 2006). In 1976, federal regulations governing implementation of coverage of suppliers of end-stage renal disease (ESRD) mandated provision of social work services to patients with ESRD (Bare in Kerson et al., 1989; Fortner-Frazier, 1981). Master's level-prepared social workers are employed in the ESRD setting to provide interventions that recognize and decrease problematic circumstances that can contribute to poor patient outcomes in all areas (Callahan, 1998, p.632). Renal social work is highly scientific and warrants the social worker to keep abreast of new dialysis terms, equipment, as well as diagnoses affiliated with dialysis such as kidney or renal failure and diabetes mellitus (Tramo, 1978, p.72).

The social worker begins the process of casework practice by exploring the possible origins of the patient's problem(s), specifically non-compliance (Berkman & Weissman, in Miller & Rehr, 1983). Social workers develop awareness of the

socioeconomic and psychological issues involved with chronic renal disease and compliance to medical care (Fortner-Frazier, 1981). A critical assessment of the social work engagement process is highly important in work with non-compliant dialysis patients in the United States (U.S.) since it is a federal mandate to have a state-licensed social worker assigned to every dialysis unit in the U.S. and its territories (DHHSCMMS 42 CFR Parts 405, 482, 488, and 498, 1976).

Dialysis social workers have a unique task of working with dialysis patients, often referred to in literature as “dialysands” (Nolph 1989), who are diagnosed with chronic kidney disease and end-stage renal failure. Dialysis social workers help dialysands with the emotional adjustment and transition to living with dialysis treatment. Social workers spend significant time with dialysands assisting with various case management duties and counseling. There may be a relational link between the stress experienced by renal social workers and the non-compliance observed in their clients. Dialysis social workers are the only federally-mandated clinicians in the fields of both social work and mental health (Beder, 1999; Browne, 2006; Prescott, 2006; Roche, 2010).

Dialysis social work is described in literature as a skillful, fast-paced, and intense genre of social work practice (Beder, 2008; Dobrof et al., 2001; Tramo, 1978). Overall, social is a highly stressful and hazardous profession (Beemsterboer & Baum, 1984; Corey, 1988; Jones et al., 1991). Medical social work practice, specifically renal social work practice, usually allows little time to process clinical reactions to patient issues (Pockett, 2003) due to the fast paced nature of the work environment (Dane & Chachkes, 2001).

Clinicians often face insurmountable amounts of workplace challenges, which may affect overall wellness such as job autonomy (Kim & Stoner, 2008), high acuity caseloads (Merighi & Ehlebracht, 2004a), ethical dilemmas (O'Donnell et al., 2008) and a lack of professional support from administrators, colleagues, and other disciplines (Um & Harrison, 1998). Studies show that social workers are at risk of experiencing high levels of stress or burnout when they experience role conflict or when their professional role goes unrecognized (McLean & Andrew, 2000; Um & Harrison, 1998).

As per U.S. Federal Regulation Public Health Code Title 42 Subpart 494.80 (Code of Federal Regulations, Regulations.gov 2013), every dialysis center must have a master's-level social worker involved in patient care due to the socioeconomic and psychological issues experienced by dialysis patients (Browne, 2006). Social work practitioners provide educational, diagnostic, and preventive treatment services to assist patients and their loved ones with the rigors of living with dialysis treatment (Beder et al, 2003; Callahan, 1998). Dialysis social workers assist patients with an array of needs ranging from general psycho-biosocial issues to living with co-morbidities such as (but not limited to) diabetes mellitus, hypertension, and HIV/AIDS (URDS, 2011) as well as other medical and social concerns.

### **Purpose of Study**

The purpose of this qualitative study was to understand characteristics and commonalities among dialysis social workers. The study examined the social workers' perceptions of work-related stressors. Social Constructivist Theory was used as a conceptual framework to analyze the responses from the sample. The validity of the proposed methodology was tested via a qualitative pilot study conducted during a

supervised student project in 2009. A new theoretical understanding about work-related stressors and stress evolved from the pilot study. Data collection was guided by grounded theory (Charmaz, 2006; Glaser, 1978; Strauss, 1987).

### **Research Question(s)**

The primary research question of this study was:

- *What aspects of dialysis social work are identified as stressful?*

The sub-questions were:

- *How does stress affect the quality of dialysis social work practice? and,*
- *What coping mechanisms and sources of social support exist that assist dialysis social workers to manage workplace stress?*

The analytical question of this dissertation was:

- *What skills, tools, or services are needed to assist dialysis social workers in managing work-related stress?*

### **Importance of the Study**

By alleviating the social work clinician's stress, the therapeutic and case management process may be more enriching for the dialysand. Although stress is a common aspect of social work practice in general, the lived experience of dialysis social work is under-explored within the realm of social science research. Further information is needed to inform practice on how to alleviate stressors as well as to develop a forum for evidence-based practice to improve the delivery of medical social services. It is important for dialysis units and centers to provide a stable and steady workforce for the communities in which they serve.

Presently, there is little information regarding how dialysis social workers perceive stress in the workplace. Most research on social work-related stress focused on the clinical and casework experiences of child protective service workers (Dane, 2000; Pryce, Shackelford & Pryce, 2007). Other social workers' experiences with stressors has not been studied. The findings from the present study might be used to inform the social work community, specifically professional groups such as the National Association of Nephrology Social Workers and NASW. This study may also promote future educational training and advocacy for dialysis social workers

### **Study Limitations**

Qualitative research provides a certain depth to research in terms of descriptive measurement (Rubin & Babbie, 2008). However, social scientists who utilize qualitative techniques have to be cautious of bias and judgment. This study yielded and revealed emotional responses regarding the experiences of social workers with their high-risk population of clients, which may be a bias in this study. Qualitative studies provide a naturalistic and generalized view of group behavior.

One of the limitations of the study was the hesitancy or reluctance of social workers to participate, based on a presumed "professional fear" of releasing and unveiling their thoughts regarding work-related stress. The participants may have opted to offer socially desirable answers similar to "gate-keeping" in order to protect their professional sense of self. The subjects may have possibly constructed a perception of professional fear of appearing weak and vulnerable. Socially-desirable answers may impact the validity of the data (Ashby et al., 2005). To prevent this likely bias, the

researcher diligently answered any questions regarding subjects' concerns; specifically, regarding the impact of their participation in this study on their professional practice.

A second limitation of this study was the small sample size and lack of diversity of the subjects. Small "N" studies always have an issue with generalizability. Hispanic, Asian, and African-American social workers were hesitant to volunteer and asked many questions about how their participation would impact their current job status. The researcher became an advocate to encourage more social workers from diverse backgrounds to participate in future research regarding professional experiences. With assistance from the National Association of Social Workers (NASW), through professional education workshops and discussions, the fears and hesitancy of social workers from different ethnic and cultural backgrounds to participate in professional research can be alleviated.

## **CHAPTER 2: LITERATURE REVIEW**

### **The Evolution of Dialysis Social Work**

Dialysis social work is highly scientific and requires the clinician to keep abreast of new dialysis terms, equipment, as well as diagnoses affiliated with dialysis, such as kidney or renal failure and diabetes mellitus (Tramo, 1978). Social workers utilize concepts such as mutual trust and aid, respect, and collaboration in order to empower dialysands to make important treatment decisions (Bordelon, 2002). It is usually the role of the social worker to assist the patient in coping with the psychosocial and environmental aspects of illness (Rock & Cooper, 2000). Social workers utilize skills such as engagement, assessment, planning, and intervention to foster relationships and establish rapport with patients (Kirst-Ashman & Hull, 1999). Such interventions are designed to contribute to the achievement of positive health and organizational outcomes (Shashar, Auslander, & Cohen, 1995).

Current literature suggests that, despite the stressors and challenges to clinical practice, dialysis social workers are providing beneficial care and are motivated to be effective in practice (Collins, 2007; Coyle et al., 2005; Ellett, 2009; Ellis et al., 2007; Ewing & Manuel, 2005; Hackett et al., 2003; Landsman, 2001; Radey & Figley, 2007; Ryan et al., 2004; Schwartz et al., 2007; Stalker et al., 2007; Wendt et al., 2011). Patient improvement serves as evidence of the benefits and effectiveness of social work case management and counseling. Johnstone (2005) reports that both mood and patient satisfaction improved by social work intervention. Research suggests that through the provision of psycho-educational support and cognitive behavioral counseling, a significant decrease in negative thought processes of dialysis patients is observed

(Johnstone, 2005). Roberts and Johnstone (2006) discovered that dialysis patients readily prefer to receive treatment for their diagnosis-related depression from their assigned dialysis social worker with whom they have an established bond and relationship.

Psychosocial factors strongly influence patient adjustment to dialysis. Social work interventions have the ability to effect dialysis patient psychosocial issues and improve patient outcomes (Bleyer, 1999). In their study of renal patients, Symister and Friend (2003) found that social support improves patient self-esteem and optimism and also lowers levels of depression. According to Dobrof, Dolinko, Lichtiger, Uribarri, and Epstein (2001), social work counseling is proven to be critical in decreasing preventable hospitalizations and emergency room visits of dialysands. Notwithstanding the exposure to stress, social workers appear to be providing effective clinical services to dialysands (Beder 1999, 2008).

Beder (1999) conducted a quantitative study that drew attention to the impact of social work counseling for dialysis patients. The study found that dialysis patients benefited from social work support and counseling. Social work counseling significantly decreased patient depression, especially during the first three months after dialysis treatment was initiated. The study reported that dialysands who received more than the standard 15 minutes of social work support on the dialysis unit showed a significant improvement on levels of depression and adjustment.

Social work services appear to be both effective and beneficial to patients on the dialysis unit despite professional challenges. Beder (2008) examined the impact of social worker staffing on depression and health related quality of life (QOL) of dialysis patients. The Beck Depression Inventory (BDI) (Hays et al., 1997) and the Kidney Disease

Quality of Life-Short Form (KDQOL-SF) (Beck et al., 1961) were the assessment instruments in the study. Of the study's 62 (N=62) participants, 31 (n=31) dialysis patients who received less time with their unit social worker had higher levels of depression. The findings appear to be substantively significant, since half of the participants had higher levels of depression. The findings of the study also inferred that dialysands who receive less social work support experience a lower QOL and higher levels of depression.

The "Tue-Thurs-Sat" experimental group, which received one third less social work support in the study (most dialysis social workers do not work on Saturdays, thus one less day of service), reported a mean BDI score of 15.9 (Beder, 2008). The "Mon-Wed-Fri" control group of the study, which received one third more time with their unit social worker, scored a mean BDI of 8.54 (Beder, 2008). The BDI scores demonstrate that the dialysands who receive more social work support have a lower depression inventory score. The dialysis social worker may have at least one case contact/interaction with the dialysand during the dialysand's three weekly scheduled dialysis appointments (Beder, 1999; Beder, 2008). The findings of the study also reflected the influence of social work support on patient wellness.

### **The Medical Aspect of Work: Kidney Disease and Dialysis Treatment**

In order to understand aspects of work-related stress, researchers provided a description of kidney disease and dialysis treatment. Dialysis social workers often acquire a basic understanding of kidney function and the disease process during the course of their work with dialysands. Chronic kidney disease (CKD) is a progressive and irreversible condition for which there is no current cure (Kalantar-Zadeh, 2010). CKD is

the initial diagnosis. When the kidney fails to function normally on its own, ESRD is fully diagnosed (Kutner, Zhang, McClellan, & Cole, 2002). The incidence of CKD has risen drastically due to risk factors such as hypertension and diabetes (Orlando et al, 2011). Chronic kidney disease may transition into ESRD; when hypertension or diabetes occurs, the patient will either undergo renal transplantation or dialysis treatment to survive (Auslander et al, 200; Kalanter-Zadeh, 2010).

The patients assigned to dialysis social workers are generally diagnosed with ESRD. Once a patient is diagnosed with ESRD, his or her kidneys are no longer functioning or assisting the body in eliminating waste. The social work professional assists the patient in understanding how ESRD will affect his or her overall emotional state, physical functioning, and ability. At this particular point of the therapeutic process, the social worker begins to engage the client in transitioning to the permanency of dialysis treatment, which is a life-changing event. Understanding the origins of a patient's medical condition and diagnosis allows the practitioner to analyze the patient's underlined pathologies, behaviors, and motives. Such an understanding is particularly important with regards to a dialysand's transition to permanent life-sustaining treatment. End stage renal disease can negatively affect a patient's social, financial, and psychological well-being (Brown et al., 2010; Ginieri-Coccosis et al., 2008).

The U.S. Renal Data System (USRDS) compiles annual statistics and demographic information regarding kidney disease and dialysis treatment (USRDS, 2011). There are a total of 370,274 patients on hemodialysis in the U.S. (USRDS, 2011). The highest incidence of ESRD and dialysis treatment occurs among Americans between ages 70-79 (USRDS, 2010). Since its development in the 1960s, hemodialysis accounts

for almost 92% of all dialysands undergoing renal replacement therapy in the U.S. (USRDS, 2011). In 2002, dialysis treatment programs consumed 6.7% of the Medicare budget (National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK, 2004). Research indicated that 20% to 25% of U.S. in-center dialysis patients die every year (Devereaux, 2002). According to current research, almost half of all dialysis patients demonstrate some form of non-compliance to one or more aspects of their regimen (Kutner et al., 2002).

### **Hemodialysis**

Hemodialysis (HD) treatment sessions are four hours in duration and are typically performed three times a week (Tijerina, 2009). Hemodialysis treatment is a mechanical and artificial cleansing of the blood in which patients must adhere to demanding medication schedules as well as fluid/dietary restrictions (Tsay, 2003; Tijerina, 2009). Hemodialysis is the process through which water, salt, and wastes are mechanically removed from a patient's body through the semi-permeable membrane within the dialysis machine (Hailey & Moss, 2000). Hemodialysis is a rigorous form of treatment. Malnutrition and cardiovascular complications are usually co-morbidities associated with long-term dialysis treatment (Radulescu, Ferechide, Davila, & Ioan, 2009).

Dialysis may be viewed as a serious life-sustaining treatment that can impose both positive and negative changes to the body. Observing the profound changes in a client's physical state can be emotionally stressful for a clinician. Patients on hemodialysis endure certain side effects and physical issues such as changes in skin tone, hypertension, cardiac issues, and diabetes mellitus. As a result of the health consequences of dialysis, a

large portion of dialysands consider HD treatment to be a burden on their quality of life (Russ Shim & Kaufman, 2005).

### **Peritoneal Dialysis**

Another form of dialysis is referred to as peritoneal dialysis treatment. In the U.S. in 2010 there was a total of 27,522 patients on peritoneal dialysis treatment (USRDS, 2011), which is a form of treatment that allows the patient to feel a greater sense of physical ownership and independence. Developed in 1963, peritoneal dialysis is a treatment method that was initially used as a consequence of patient intoxication, acute renal failure, and intractable edema (Edelman et al., 1968). In its beginning phases, peritoneal dialysis was used as a temporary therapy while diagnostic and prognostic evaluations were performed by physicians (Edelman et al., 1968). The solution contains a sugar called dextrose that extracts wastes and extra fluid into the abdominal cavity (NIDDK, 2010). The wastes and fluids leave the body when the dialysis solution is drained (Kutner et al., 2002). The used solution containing wastes and extra fluid is then discarded (NIDDK, 2010). The process of filling and draining is referred to as an exchange and takes about 30 to 40 minutes (USRDS, 2011). The period of time in which the dialysis solution is in the abdomen is referred to as the dwell time (Ginieri-Coccosis et al., 2008). Four exchanges a day are usually a part of the assigned peritoneal dialysis (PD) schedule, and are set four to six hours apart (Mavromates, 2005).

There are two types of peritoneal dialysis; first is continuous ambulatory peritoneal dialysis (CAPD) and second is continuous cycling peritoneal dialysis (CCPD), which is sometimes referred to as automated peritoneal dialysis (APD) (NIDDK, 2010). Continuous ambulatory peritoneal dialysis does not require a machine and patients are

able to walk around while receiving treatment (Zirogiannis et al., 1995), while CCPD requires use of a machine and is usually performed while the patient is sleeping (NIDDK, 2010). Continuous ambulatory peritoneal dialysis is increasingly being used in patients with ESRD (Jong et al., 2011). The advantages to using the CAPD method of dialysis over CCPD dialysis are the reduced incidence of hernia and lower incidences of peritonitis, which is a rupture or infection of peritoneum membrane (Brunkhorst et al., 1994; Holley et al., 1990; Rodriguez et al., 1998). Peritoneal dialysis is relatively inexpensive, does not require intensive training, and is a non-vascular approach to renal replacement therapy (Ansari, 2011).

### **Issues with Hemodialysis and Peritoneal Dialysis Treatment Use**

Both modalities of dialysis treatments have positive and negative attributes. Patients often rely on the interdisciplinary team to find the best dialysis method that meets their needs. However, research indicated that issues of body image, nutrition adherence, dietary changes, various physical problems, and other adversities affect users of both PD and HD (Ginieri-Coccosis et al., 2008; Mavromates, 2005; Zirogiannis et al., 1995). Both PD and HD are challenging health care treatments that have numerous physical and emotional effects on patients. Both methods are considered life-sustaining treatments. Failure to comply with any one of the recommended regimens exposes the patient to be at higher risk for infection, other co-morbidities, emergency room visits, and even untimely death. Clinical work with persons on life-sustaining treatment is challenging. The clinical interaction may result in symptoms of work-related stress.

### **The Mandated Implementation of the KDQOL-36 (1994; 2000)**

Dialysis social workers have two federally mandated functions; first, to serve as a member of the dialysis interdisciplinary team, and second to conduct the newly mandated annual quality of life survey with each dialysis patient (Prescott, 2006; Rocha, 2010). On April 1, 2008, the Centers for Medicare & Medicaid Services (CMS) added an additional professional mandate that requires dialysis social workers to conduct an annual standard QOL assessment survey on every dialysis patient assigned to their caseload (Rocha, 2010; Schatell & Witten, 2012).

The survey is known as The Kidney Disease Quality of Life Survey-Study 36 (KDQOL-36) (KDQOL36, 1994; 2000). In addition to administering the survey, the dialysis social workers are also responsible for discussing the survey results with each client. The survey results are based on the national average mean of patients compared in the same age, gender, and diabetes status group within one standard deviation of the mean (Schatell & Witten, 2012). Lower scores are an indication of high risk for hospitalization and mortality. Higher scores are an indication of wellness and positive health outcomes in dialysis treatment. Current literature concluded that the addition of the new professional mandate brought forth a new stress-inducing task for dialysis social workers in addition to the already existing high caseloads and large volumes of paperwork (Rocha, 2010).

The KDQOL-36 (1994) is a Likert-type scale survey designed in 1994 as a renal-specific assessment of Health Related Quality of Life (HRQOL) (Guo et al., 2002; Lowrie et al., 2003). The survey is comprised of 36 questions; 12 questions are items

from the Medical Outcomes Study Short Form 36 (MOS SF-36) and the other 24 questions are about renal health specific issues (Mapes et al., 2003).

The questions address topics such as awareness of symptoms, the challenges of chronic illness, social and staff support, and client satisfaction. The survey can be administered manually or online. The survey takes about 10-15 minutes to complete (Schatell & Witten, 2012). The patient receives the results and the results are also entered into the medical chart to ensure CMS compliance. The social work professional is required to explain the survey results to the patient (Rocha, 2010; Schatell & Witten, 2012). The KDQOL Complete (1994) is the computer service that scores the surveys (Lacson et al., 2008; Schatell & Witten, 2012). The scores are divided into three categories: above average, average, and below average (Schatell & Witten, 2012). The social workers use the scores to address treatment goals, make referrals to community-based services to assist the client in coping and to formulate a new strategy to improve healthcare outcomes.

### **The Challenges of Using the KDQOL-36**

There are several challenges and issues that arise in the use of the KDQOL-36 (1994) survey. The most prominent concern is the fact that the survey has several exclusions. The mandated regulations exempt dialysands who are under 18 years of age (children), patients who have cognitive impairments such as dementia or active psychosis, and patients who speak a foreign language that it is difficult to readily find language interpretation from taking the annual quality of life standard assessment (Schatell & Witten, 2012).

The exclusions exempt patients who often need more assistance and psychosocial support. Social workers are concerned with the exclusions because adolescents have a rate of 59% poor adherence to dialysis care (Kurtin et al., 1994). This data suggest that adolescents would benefit from annual quality of life assessment. Adolescents and young children require supplemental assistance in transitioning to dialysis care and accomplishing positive outcomes in treatment Brady & Lawry, 2000; (Fielding et al., 1985).

Patients who are cognitively impaired are also exempt from the mandated quality of life survey. Those who are diagnosed with ESRD are more likely to commit suicide than those who are not living with the disease (Browne, 2006; Kurella, Kimmel, Young, & Chertow, 2005). Psychological issues such as depression are linked to more hospitalizations and decrease of quality of life on dialysis (Browne, 2006; Kalantarr-Zadeh et al., 2001; Molloaoglu, 2004; Paniagua et al., 2005).

Dialysands for whom English is a second language may experience cultural, environmental, social, and financial barriers. Patients with certain needs require additional support and continuous evaluation (Browne, 2006). The KDQOL-36 (1994) indirectly obligates social workers to discuss death and dying issues with clients who score low or below average on the survey (Schatell & Witten, 2012). For some clinicians, discussions about mortality can be uncomfortable due to the fragile nature of the patient's health. According to some articles, the obligation to address mortality issues places an unnecessary weight on the dialysand-social worker dyad/clinical relationship (Roche, 2010).

The KDQOL-36 (1994) requires more paperwork. According to the findings of one study that recruited 809 (N=809) dialysis social workers, 94% reported performing clerical work; only 34% of the respondents stated that they had enough time to address psychosocial issues with their clients due to the heavy volume of work (Merighi & Ehlebracht, 2004b; 2004c; 2005). In another study of dialysis social workers, Bogatz, Colasanto, and Sweeney (2005) found 68% of the subjects stated they did not have enough time to perform casework and counseling, while 62% did not have enough time for patient education counseling. The study found that social workers feel hindered by their case loads (Bogatz, Colasanto, & Sweeney, 2005). According to Roche (2010), the KDQOL-36 (1994) survey mandate may be viewed as a professional burden due to the existing stressful experience of dialysis social work.

### **Work-Related Stress and the Perception Thereof**

There is significant stress found in social work practice by practitioners. “Stress is a necessary component of our lives, without which we would die, too much stress is toxic” (McConnell, 1982, p.70). Stress is simply defined as the “physical and emotional reactions to life’s events” (Haroun, 2011, p.55). Stress can also be defined as the harmful physical and emotional reactions experienced when job functions do not mesh with the capabilities, resources, or requirements of work (National Institute for Occupational Safety and Health, 2003; Rai, 2010).

In order to understand the nature of dialysis social workers’ experience with work-related stress, the symptoms, causes, and effects of stress will be discussed in this section. Causes of work-related stress can be categorized as physical, social, and/or emotional. Physical causes of work-related stress may be viewed as those factors in a

social worker's environment that can initiate physical distress such as noise, air pollutants, radiation, dangerous machinery, physical injury, and serious illness (McConnell, 1982).

There are also significant barriers or factors in regards to accessing certain healthcare services that continue to be stressful aspects of dialysis social work practice (Browne, 2006). Issues such as access to child care, transportation, work schedules, and health insurance eligibility can become barriers to healthcare access (Ahmed et al., 2001). Finding reliable resources for patients is a significant concern for dialysis social workers (Rocha, 2010). Dialysis social workers are in an environment where people are physically ill, disabled, and sometimes terminally infirmed, which is often most challenging (Khan, 2003).

Work-related stress is a serious issue for social workers because a clinician's perception of stress can influence adjustment (or maladjustment) to the various stressors and stressful conditions at work. Work-related stressors can negatively impact or potentially harm clients and social workers. Merighi, Browne & Keenan (2009) conducted a quantitative study that found that dialysis social workers and kidney transplant social workers may be more susceptible to burnout than other professionals. Social workers can be placed at greater risk for a decrease in coping skills, decreased awareness of ethical concerns, a lower sense of professional and personal accomplishment, loss of spiritual connection, and an increase in interpersonal conflict if these factors are unaddressed (Everall & Paulson, 2004; Hyman, 2004; Salston & Figley, 2003).

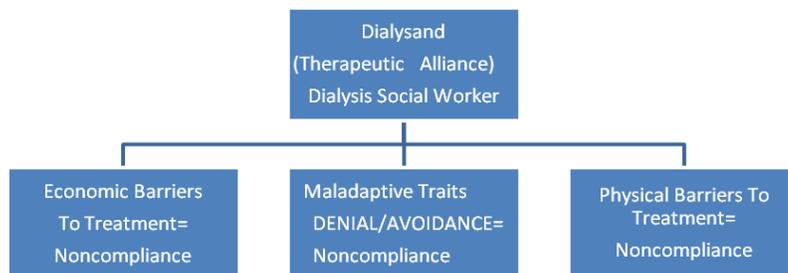
Recent literature suggests that social workers in general experience negative effects as a result of exposure to work-related stressors in practice (Fothergill, Edwards, & Burnard, 2004; Nelson-Gardell & Harris, 2003; Sprang, Clark & Whitt-Woosley, 2007). Current research indicates that 20% to 35% of social workers experience problems and impairments in their practice due to exposure to stress at work (NASW, 2006; Pooler et al., 2008; Pooler, 2010). Insufficient pay, unsupportive agency leadership, consumer issues and behaviors, along with other workplace demands are cited as work-related stressors that can impair clinical work (Pooler, 2010). Work-related stressors, such as high volume caseloads (Newell & MacNeil, 2010), staffing issues (Rau-Foster & Dutka, 2004), and the lack of peer and supervisory support (Mor Barak, Nissly, & Levin, 2001) may have a detrimental impact on the professional performances of social workers. Social work-related stressors may result in poor work attendance/high absenteeism rates (Dane & Chachkes, 2001; Grassi & Magnani, 2000; Elloy, Terpening, & Kohls, 2001), burnout ( Harrington, Bean, Pintello, & Mathews, 2001; Huang, Chuang, & Lin, 2003; Maslach et al., 2001), and job turnover (Cyphers, 2001; Lloyd, King, & Chenowith, 2002; Kim & Stoner, 2009; Mor Barak , Nissly, & Levin, 2001;).

Perception is the way one sees the world and experiences the world through both sensory and cognitive processes (McDonald, 2012). Perceptions usually challenge internal systems and group sense of security. Perceptions also reveal inter-connections within systems (Snetkov, 2012). There are three defining attributes associated with perception: “sensory awareness or cognition of these experiences; one’s personal experience; and, comprehension that can lead to a response” (Walker & Avant, 2005 in McDonald, 2012, p.5). Perceptions are based on an “individual’s or group’s unique way

of viewing a phenomena, involving the processing of stimuli, and incorporating memories and experiences in the process of understanding” (McDonald, 2012, p.8). In order to fulfill the future industry demands of dialysis social work, clinicians must address perceptions of stressors that may negatively impact patient care and the effectiveness of social work services.

### **The Role of Patient Non-compliance in Work-Related Stress**

Non-compliance in dialysis work can be a stressful experience for a helping professional seeking to assist a client in achieving treatment goals (Leggat, 1998). Non-compliance is a major concern within the therapeutic milieu of dialysis work (Kutner et al., 2002). Figure 1 illustrates the internal and external constructs that affect the therapeutic alliance.



*Figure 1.* Illustration of the Influence of Non-compliance as a Stressor in the Therapeutic Alliance. This diagram was developed by the writer of this dissertation based on the research conducted.

Figure 1 illustrates the internal and external constructs that affect the therapeutic alliance. Social constructs such as economic barriers, maladaptive traits (i.e., denial and avoidance), and physical barriers to treatment such as the lack of physical energy affect compliance with dialysis treatment. Non-compliance is defined as “the degree to which

behavior fails to coincide with medical recommendations such as prescribed medication, medical appointments, and other preventive health measures” (World Health Organization, 2003, p.17). Non-compliance may be inadvertent or intentional (Allen, Wainwright, & Hutchinson, 2011). Non-compliance can also be described as the act of a patient “failing to follow the advice or prescription of a physician” (Burcher, 2012, p.74). Such is a defense mechanism in coping with the physical and emotional loss associated with dialysis treatment. The following is the formal explanation of non-compliance in the DSM-IV-TR (2000):

The reasons for non-compliance may include discomfort resulting from treatment (e.g., medication side effects), expense of treatment, decisions based on personal value judgments or religious or cultural beliefs about the advantages and disadvantages of the proposed treatment, maladaptive personality traits of coping styles (e.g., denial of illness), or the presence of a mental disorder (e.g., Schizophrenia, Avoidant Personality Disorder). This category should be used only when the problem is sufficiently severe to warrant independent clinical attention. (DSM-IV-TR, 2000, p.739)

Patient non-compliance may reduce the effectiveness of recommended treatment and may also have an overall detrimental effect on a patient’s life, resulting in shorter life (Paddison, 2002). Non-compliance may also be construed as a violation of the mutual trust between a patient, physician, and social worker since there is a mutual sharing of trust within the patient-physician relationship (Ricoeur, 2007). Non-compliance is a significant stressor experienced in dialysis social work.

Social workers play a significant role in encouraging compliance. The goal of counseling and case management in the dialysis realm is to assist the client in becoming more compliant and decreasing the stressors that foster non-compliance. Aiding clients with issues of medical compliance is a large aspect of dialysis social work practice (Dobrof et al., 2001; Tramo, 1978). The dialysis social worker engages the dialysand in

what was referred to in literature as a *reparative process* or *reparation* (Frogget, Farrier & Poursanidou, 2007, p.105) to begin internal and physical healing. Social workers often assist dialysands in recognizing and exploring the potential risk and harm non-compliance may have on the emotional and physical self. The perspective is based on Klein's contributions to Object Relations theory and psychoanalytic thought (Frogget, Farrier & Poursanidou, 2007; Klein, 1992). In essence, the perspective suggests that dialysands often view themselves as the "other," objectifying their overall experience to deflect their feelings and emotions. Thus, the clinician meets the client at this point in counseling to explore his/her feelings to cope and alleviate the noncompliance.

Non-compliance is a major barrier in treatment for both the clinician and client. Non-compliant behavior provides one readily available way for ESRD patients to deflect the perceived intrusion of kidney disease and dialysis into their daily lives (Kutner, 2002, p.94). Factors leading to non-compliance may include economic reasons, such as lack of transportation to obtain treatment. Affordability of medical co-payments and other health care costs may serve as challenges for dialysands and the professionals who seek solutions to case management issues (Bleyer et al., 1999). Physical health barriers, such as simply not feeling well to complete treatment, may also serve as a factor in patient noncompliance (Boyer, Friend, Chlouverakis, & Kloyanices, 1990). Dialysis social workers aim to assist patients and their families to resolve non-compliance issues, thus improving patients' and families' sense of well-being and levels of compliance.

Demographic characteristics are also related to dialysis treatment compliance. Researchers reported that, in general, men, African-Americans, younger patients, and those with income below the poverty level tend to be less compliant overall with renal

care (Cukor, Rosenthal, Jindal, Brown, & Kimmel, 2009; Kutner et al., 2002; Tijerina, 2009). Longer treatment history and immigrant status are also factors that increase non-compliance with treatment (Tijerina, 2009).

Non-compliance can lead to redundant and excess healthcare costs (Cukor et al., 2009). Some effects and outcomes of non-compliance include unnecessary visits to the emergency room, random ambulance/Medicaid reimbursed transportation fees, and superfluous overtime pay for medical professionals providing care for unscheduled patients (Bishop, Rodrigue, & Wingard, 2002). Non-compliance to healthcare maintenance is an overall major industry concern and can also lead to loss of life (Kutner et al., 2002). Many non-compliant dialysis patients fail to seek out mental health treatment because: a) it never occurs to the; b) physicians on the unit have not referred them for evaluation and/or treatment; or, c) they knowingly resist seeking help (Smetanka, 2006). Based on research findings, non-compliance should be addressed by dialysis social workers within the therapeutic alliance. Dialysis social workers can seek advice and use their supervisors as resources to find ways to help promote compliance with treatment.

### **Social Constructivist Theory and Dialysis Social Work**

According to Mascolol & Fischer (2005, pp 49-63), constructivism consists of the philosophical and scientific position that knowledge is built through a series or process of active learning and construction. John Dewey (1933) is cited for providing the philosophical foundation for this theory. Bruner (1990) and Piaget (1972) are considered the prominent theorists among the cognitive constructivists. However, the contributions of Vygotsky (1934) allowed him to become the principal and most influential theorist

among the social constructivists. Vygotsky (1934) emphasized the role of language and culture in intellectual development and formation of personal perceptions.

Vygotsky (1934) also conceptualized that learning takes place within what is referred to as the Zone of Proximal Development (Vygotsky, 1978, pp. 34-41).

The zone is made up of two distinct developmental levels (Crawford, 1996, pp.43-62):

- a) Level One: The level of actual development which describes the point the client/learner has already reached and can problem solve independently.
- b) Level Two: The level of potential development in which the person is capable of developmental achievement under the guidance of a clinical professional, teacher, or peer.

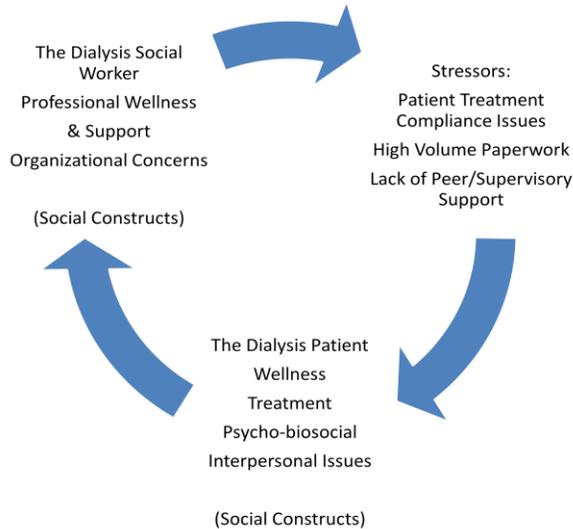
According to Newson and Newson (1975, pp.437-446), the development of Zone Development Proximity (ZDP) was guided by three major ideas:

- a) Intersubjectivity- participants/clients start at different points but eventually arrive at a shared understanding.
- b) Scaffolding- when the clinical professional/teacher/peer adjusts the support offered which suits the client's/person's current level of functioning or performance.
- c) Guided Participation-refers to shared experiences between a clinical professional/teacher/peer mentor and their client, student, or fellow peer.

Social constructivist theory (Dewey, 1933; Vygotsky, 1934; Piaget, 1972; Bruner 1990) focuses on the perception of what occurs in society and the knowledge built on the understanding that evolves from a process of mutual agreement linked to traditions,

language, and culture of a community (Cottone, 2007, pp. 189-203). The theory is a post-modern approach that helps social workers better understand their client's experiences.

Social constructivist theory (Dewey, 1933; Vygotsky, 1934; Piaget, 1972; Bruner 1990) also serves as a vehicle in helping the clinicians maintain a sense of self-awareness during the interaction process with clients. The theory is helpful in understanding how stress becomes a social construct for both the clinician and client during their working relationship. Figure 2 illustrates the connection between the dialysand, the dialysis social worker, and professional stress in the context of the social constructivist theory and highlights the various layers and constructs that combine and merge to form the professional community of the dialysis social worker. The arrows in the diagram demonstrate the movement of the conceptual categories or constructs. The categories continue to shift and change during each phase (namely the beginning, middle and end) of the therapeutic process.



*Figure 2.* Influence of Social Constructs and Stressors on the Clinical Relationship between Dialysand and Social Workers. This diagram was developed by the writer of this dissertation based on the research conducted.

Social constructivists believe that reality is created by individuals (Mo-Yee & Gilbert, 1999). Social constructivism is heavily rooted in social psychology (Gergen, 1985; Mead, 1934). During social interaction, our knowledge connects us with others and the surrounding world (Assmann, 2008). We are always learning about who we are and about others through social interaction in the context of social systems. The theory assumes that systems are self-defining and self-managing in nature (Maturana & Vasela, 1992 in Mo Yee & Gilbert, 1999). Knowledge evolves when systems are stressed to change in order to accommodate the environment (Elkaim, 1990; Held, 1995; Mo-Yee & Gibert, 1999). Human beings often use social interaction as a way of categorizing their own sense of reality (Gergen, 1994) that is based on their personal life history and culture (Greene, Jensen, & Jones, 1996). Dialysis social workers tend to use constructs to help their clients relate to the changes in their health, families, and global communities.

Consciously or unconsciously, social workers also use constructs to understand and cope with the stressors involved in working with dialysis patients.

Social workers react and respond to stress based on their personal belief system and the way other colleagues perform (Newell & MacNeil, 2010). The use of constructs allows social workers to assist clients in understanding different aspects of their issues, problems, and life style. The social constructivist perspective also explores how clients construct their own realities and meanings (Tijerina, 2009).

In terms of dialysis social work practice, both the dialysand and the social worker are members of the patient care community. Each dialysand has his/her own story about why he or she began dialysis treatment. Most often, every social worker has his/her own story about why he or she chose dialysis care as a field of professional practice. The social worker's background and status also influences service delivery. The social work practitioner is also an individual in the system or community. Dialysis social workers experience changes and periods of reflection as they help their clients process issues.

Social constructivism challenges our present knowledge base and the way knowledge becomes accepted as truth (Burr, 1995). The clinician and the patient actively construct their understanding of the world as they socially interact within the community (Lyddon, 1995). Constructivism explains that one can be objective about reality without taking into consideration his or her own views, biases, and personal experiences (Dean, 1993; Hoffman, 1990). Social constructivism offers a relational focus to clinicians whose clients are affected by social and economic inequalities because the theory emphasizes the degree to which individual beliefs are determined by one's position in society (Dean, 1993). Social barriers may be considered constructs that create challenges to access

treatment and care for dialysis patients. Research indicates that social workers experience stress due to the significant challenge of helping clients find solutions to their problems (Baird & Jenkins, 2003; Hyman, 2004; Kinzel & Nanson, 2000; Iliffe & Steed, 2000; Trippany, Kress, & Wilcoxon, 2004).

Dialysis social workers naturally experience stressors as they find their niche in the community while assisting clients in the therapeutic process. Social constructivism assumes that the clinician's experience in the community is reflexive, driven by the client's will and expressions (Anderson & Goolishian, 1988). In the therapeutic alliance, "questions are the tools of the therapist in a therapeutic conversation, and they are to be guided and informed by the views of the clients so that the conversation is geared toward the maximum production of new information" (Dean, 1993, p. 65).

The theory has been used in major recent major studies. Tijerina (2009) used social constructivist theory to examine noncompliance among Mexican-American women receiving dialysis treatment. Tijerina recruited a purposive sample of 26 (N=26) Mexican-American women to participate in an interpretive study approach. The findings suggested that constructs such as income, educational level, and immigration status affected adherence to dialysis treatment.

Dane and Chachkes (2001) used the self-constructivist model to explore the work experiences of hospital based social workers. The study used data from focus groups conducted with hospital social workers. The study explored the effects of medical social work practice on social workers. The study also found that social workers brought home their job stress, worried about their clients, and were unable to separate themselves from their clients' problems (Bourassa, 2009; Dane & Chachkes, 2001).

There was also discussion regarding finding ways to improve productivity, reviewing the challenges for new professionals to set boundaries, and not receiving credit for their professional skill base on interdisciplinary teams and within their departments. Some of the participants also shared that they tend to avoid patients due to their high caseloads and volume of work. Participants also felt unsupported by their administration to do more for clients. A few participants in the focus group shared the need to stay after work hours to complete tasks and engage clients. Four consistent themes emerged from the focus groups: organizational stress; feelings of guilt; problems in coping with the psychological impact of cases; and, social supports (Danes & Chachkes, 2001).

The social constructivist approach allows a clinician to purposefully guide a client to his/her own understanding about his or her perceptions regarding dialysis treatment. The approach is valuable in understanding how client's lives are significantly impacted and challenged by psycho-biosocial barriers to treatment such as economic strain and poverty, transportation issues, family concerns, and immigration status and access (Gokcakan, 1991; Ginieri-Coccosis et al., 2008; Kennedy, Craven, & Rodin, 1989; Oikonomidou et al., 2005; Tijerina, 2009; Wu et al., 2004). Social constructivism assists in understanding how the clinician uses social constructs to interpret patient illness (kidney failure/dialysis) and work-related stress in their engagement with patients.

Social constructivist theory was used in the thematic coding process of this proposed study to find meaning in the professional perceptions of stress. This included making the connection between working on a dialysis unit (which included the lived experience of patient illness and dialysis treatment through the lens of the practitioner), with dialysis social work practice and the possible professional stress that may be

experienced in this therapeutic milieu. The theory is considered to be a strengths-based approach to practice (Paquin, 2006; Saleebey, 1997; Saleebey, 1998) and is reflective of the professional emphasis of client self-determination and client individualism (Goldstein, 1990; Paquin, 2006; Reid, 2002; Weick et al, 1990).

### **Stressors in Dialysis Units**

To understand the root causes of the social work stressors experienced on the dialysis unit, an examination of key issues that may promote stressors in the unit setting was critical. One of the key stressors is patient noncompliance, which is a critical issue in patient care and a major stressor and professional challenge in dialysis services. According to literature, most dialysis patients demonstrate some form of non-compliance ranging from the non-cessation of smoking, poor weight control, poor diet, poor adherence to fluid intake restriction, and not attending dialysis treatment sessions (DiMatteo, Lepper, & Croghan, 2000; Tsay, 2003). Furthermore, engagement with patients who are non-compliant with dialysis treatment may also have a negative impact on a professional's sense of self (Friedman, 2001). Recent articles suggested that professional obstacles such as patient non-compliance may lead to an erosion of a social worker's sense of leadership, spirituality, and self-worth (; Bourassa, 2009; Trippany et al., 2004).

### **Patient Acuity Level as a Professional Stressor**

Dialysis social workers are responsible for assessing a patients' acuity level as it relates to their psycho-social well-being; this task is identified as a major stressor for social workers on dialysis units (Ewers, Bradshaw, McGovern, & Ewers, 2002; Zapf, Seifert, Mertini, & Holz, 2001). A patient's acuity level can be determined using the

clinical classification guidelines of stages one to five (ranging from normal kidney function (stage one) to the most severe kidney failure (stage five) as defined by the National Kidney Foundation's Kidney Disease Outcomes Quality Initiative (NKF, 2002).

Acuity is defined as the severity level of a patient (Stedman's Medical Dictionary, 2005, p. 22). In dialysis social work practice, the term *acuity* (specifically, high or low acuity) developed into a dialysis social work term (jargon) to describe the severity and complexity of an individual patient and/or an entire caseload. Understanding the complexity of a patient's acuity may be viewed as a stressor because the social worker must relate to his or her patient's prognosis or mortality (Roche, 2010). Helping professionals who work with high risk/acuity populations often experience emotional exhaustion due to the serious nature of their work (Maslach, 1977). As with other types of medical social workers, professionals on dialysis units are at high risk to experience work-related stress due to coping with the various states and aspects of chronic illness (Dane & Chachkes, 2001; Grassi & Magnani, 2000). Stress may eventually lead to burnout, which is defined as "the physical and emotional exhaustion often caused by overwork and feeling that one's efforts are not appreciated" (Haroun, 2011, p. 55). Overall, stress is an inevitable and unavoidable experience in the field of social work practice (Maslach, Sclauflei & Leiter, 2001).

### **Social Issues Among Colleagues and Other Professionals**

Social factors often influence interpersonal interactions with clients, administrators, colleagues, and others who are a part of the organization or agency environment (McConnell, 1982). Helping professionals often experience internal and external pressure to perform well for the sake of their clients (Clark, 1980).

Dane and Chachkes' (2001) research highlights the issues of stressors among colleagues. The sample was comprised of 12 (N=12) full-time social workers employed by New York University Medical Center (2001). Data were collected using a focus group interview format. The purpose of the study was to understand the stressors faced by medical social workers. The practitioners voiced concerns regarding the lack of recognition in the workplace and needing to verbally share their stressful experiences at work with family, friends, and peers. The subjects also commented on feelings of powerlessness while collaborating with other disciplines, such as nurses and doctors. Subjects discussed the stress caused by little time to efficiently engage clients along with their families in counseling and case management duties. Other themes included feelings of immense pressure to discharge patients by doctors and nurses as well as lack of respect by other disciplines.

The data also revealed that social workers brought home their job stress, worried about their clients, and were unable to separate themselves from their client's problems (Bourassa, 2009; Dane & Chachkes, 2001). There were also issues regarding skills and tools to improve productivity, reviewing the challenges for new professionals to set boundaries, and not receiving credit for their professional skill base on interdisciplinary teams and within their departments. Some of the participants also shared that they tend to avoid patients due to their high caseloads and volume of work. Participants also felt unsupported by their organizational leaders and pressured to service more clients. Four major themes emerged from the focus group session: organizational stress; guilt; problems in coping with the emotional impact of cases; and, social supports (Dane & Chachkes, 2001).

## Emotional Factors of Work-Related Stress

Emotional factors that may influence stress are the perceptions of the clinician's relationship to the professional community that can lead to anger, fear of success or failure, disapproval, anger, and anxiety (Albrecht, 1979; McConnell, 1982). Helping professionals often use methods, such as detached concern, intellectualization, compartmentalization, withdrawal, and reliance of other staff members consciously or unconsciously, to handle stress at work (Pines & Maslach, 1978). Rationalization or intellectualization refers to the cognitive ability to reframe a professional's perceptions in order to explain or justify an uncomfortable situation (Butler & Astbury, 2008). Displacement, withdrawal, and detached concern are defense mechanisms used to redirect one's emotions, thoughts, and feelings that may develop during the therapeutic process (Butler & Astbury, 2008; Vergara, 1984). Emotions such as detachment and withdrawal are natural responses to stress in the professional setting.

Clinicians may feel detached or vulnerable when their beliefs about the world and humanity are challenged by their experiences with their clients (Courtois, 2002). The act of undoing or withdrawing in clinical practice occurs when one attempts to reverse or counteract an unacceptable or inappropriate behavior (Butler & Astbury, 2008; Hamachek, 1992). An example is when a social worker raises his or her voice out of frustration during a session with a client.

The terms *reliance*, *sublimation*, and *compensation* refer to the professional defense of overcoming challenges, weaknesses, and other barriers in an organization by being successful and accomplishing more in the workplace or setting than others do (Butler & Astbury, 2008; Smith, 1998). Literature explains that acts of denial, avoidance,

compartmentalization, and suppression are means of minimizing and counterbalancing uncomfortable stressors that can lead to depression and other negative outcomes (Clark, 1987; Gibson, 1989; Gross, Mcilveen, Coolican, Clamp, & Russell, 2000; Hamachek, 1992; Jackson & Sullivan, 1994; Martin, 1982; Maylon, 1982; Schneider, 1991; Troiden, 1989; Uribe & Harbeck, 1992).

Working with patients who are on dialysis can evoke and cause emotional stress. Clinicians may experience an inability to set limits and, develop low self-esteem, competitiveness, compromised personal values, and sense of self as well as an overall lack of personal control (Applebaum, 1980). Such feelings can heavily impact not only practitioners, but their interaction with clients and the organization at large.

### **Organizational Stress Factors**

Organizational stress factors can also influence individual professional experiences with work-related stress. Organizational stressors may include lack of opportunities for promotion/training, lack of unit supervision/team support, high volume of paperwork, role conflict, limited vacation time, lack of adequate workspace, and low salary potential (Spaniol & Caputo, 1978). The category of work conditions included factors such as staff shortages, caseload, shift/staffing patterns, less work/field experience, and limitation of work materials (Brokalaki, Matziou, & Thanou, 2001; Lewis et al., 1992; Nakahara, Morita, & Uchida, 2004).

Work can have a significant impact on a clinician's world view (Cunningham, 2003). Work-related stress often affects the professional worth of social work professionals. Iliffe & Steed (2000) conducted a study on domestic violence workers in which social workers reported feeling "ineffectual, inadequate, powerless, stressed and

anxious” (p.399). The social workers who participated in the study stated that they questioned their competency and skill level due to their stressful work experiences. As stated earlier, work related stressors can erode a social worker’s sense of spirituality, self-worth, and personal faith (Bourassa, 2009; Trippany et al., 2004). Organizational stressors may lead to organizational behaviors or reactions in social workers and other helping professionals in response to stress (Newell & MacNeil, 2010). On a dialysis unit, the professional response to stress can be detrimental to the health and well-being of the dialysis patient. Low achievement of clinical and administrative duties can also be viewed as warning signs of burnout. Despite evidence that some clinicians are experiencing compassion fatigue and other mental health aberrations related to stress, many clinicians are not “stressed or burned out” and remain committed to the field (Figley, 2002).

Various disorders are related to social workers sharing the emotional burden of their client’s issues (Bride, Radey, & Figley, 2007). Dialysis social workers experience and process the emotional burden weekly with their clients on the dialysis unit. Stress can develop into many different pathologies and related disorders (Maslach et al., 2001). Vicarious traumatization (McCann & Pearlman, 1990) refers to the change in cognitive schemas and belief systems resulting from exposure to client trauma that may disrupt a practitioner’s sense of meaning, tolerance, and identity (Courtois, 2002). Secondary traumatic stress is the behavior and /or emotions resulting from the knowledge and assisting or the desire to assist due to a trauma experienced by a significant other or client (Bride, Radey, & Figley, 2007). Post-traumatic stress disorder is almost identical to the definition of secondary traumatic stress but includes symptoms such as intrusive imagery,

avoidance, hyperarousal, distressing emotions, cognitive changes, and functional impairment (Bride, Radey, & Figley 2007; Figley, 2002; Figley & Roop, 2006).

According to O'Donnell et al., (2008), when stress is not addressed, it may lead to job dissatisfaction and eventually cause social workers to leave the profession entirely. Not addressing stress is an important concern for the dialysis social work community, since consistency and continuity of weekly case contact with clients is federally mandated (Auslander, Dobrof, & Epstein, 2001; Council of Nephrology Social Workers, 2002; Prescott, 2006). Most discussions regarding stress often include the concept of burnout, which is a common outcome of work-related stress. The first researcher to conceptualize burnout was Freudenberger in 1974 (Pearlman & Hartman, 1982; Rai, 2010). Most of the early research on burnout was descriptive and lacked quantitative information (Rai, 2010). Burnout can be analyzed qualitatively or quantitatively, since it occurs over a period of time with contributing factors related to both the individual, the clients served, and the agency (Maslach et al., 2001; 2003a; 2003b).

The concept of "burnout" is a multidimensional process or meta-construct with three domains: emotional exhaustion, depersonalization, and reduced sense of personal accomplishment (Maslach et al., 2001; Newell & MacNeil, 2010). Emotional exhaustion refers to the state that occurs when social workers' emotional resources become diminished by the chronic needs, demands, and expectations of their clients, supervisors, and organizations (Newell & MacNeil, 2010). Depersonalization (which is also referred to as cynicism) refers to the negative or severely detached responses to peers or clients and their problems (Maslach, Schaufeli, & Leiter, 2001). The social worker may undergo

changes in interpersonal relations regarding his/her practice that may occur during the process of professional burnout.

Helping professionals may be motivated and inspired by a sense of professional satisfaction called compassion satisfaction. Social workers and other human services professionals experience a balance between compassion fatigue and compassion satisfaction (Stamm, 2002). Compassion fatigue describes the symptoms that are experienced by social workers and other caring professionals who work with clients dealing with trauma (Bourassa, 2009). The symptoms and signs of compassion fatigue include avoidant responses, sadness, irritability, difficulty concentrating, depression, and anxiety. Social workers may also experience detachment from others, physiological responses, and addictive behaviors. Such symptoms must exist for a month before being diagnosed as compassion fatigue.

### **Supervision**

Social work supervisors play a pivotal role as teachers, enablers, consultants, and managers for direct service workers (Kadushin, 2002). Effective supervisors must provide direct practice social workers such as dialysis social workers with specific guidelines and professional skills while building mutual trust through the method of open-communication with their supervisees (Kim & Lee, 2009). Numerous studies suggest that perception of supervisor support and communication are associated with levels of burnout and workplace retention (Mor Barak, Nissly, & Levin, 2001; Ray & Miller, 1991; Um & Harrison, 1998;).

Dialysis social workers require administrative and collegial support to develop a strong sense of coherence due to the many challenges faced working with resistant

dialysands. In relation to dialysis social work practice, organizational risk factors have an important impact on professional stress and the quality of service provision.

Supervision plays a vital role in alleviating stressors of the workplace and promotes employee effectiveness (Mor Barak et al., 2001).

Mor Barak et al. (2001) conducted a meta-analysis of quantitative research regarding outcomes of supervision of 32 qualified articles written between 1990 and 2007, with a combined number of subjects of N= 11, 937 social workers from child welfare, social work, and mental health settings. The researchers report that all three dimensions of supervision categorized by the study (emotional/social support, task assistance, and interpersonal interaction) were positively and significantly related to beneficial worker outcomes (Mor Barak et al., 2001). The main goal of the study was to establish the factors associated with beneficial versus non-beneficial outcomes in supervision in order to make recommendations to improve supervision.

### **Gaps in Current Literature**

The present study fills existing gaps in current literature about work-related stress, social workers, and dialysis work. Recent literature describes work-related stress experienced in dialysis work as a byproduct of the patient's experience. In other words, stress experienced in clinical practice may be viewed as a direct result of the client's high or low acuity level. For example, Beder (2008) made an effective argument for improving staffing issues in dialysis social work based on two client variables: the depression levels of dialysands and the benefits of client exposure to social work case services. Few studies document the ideas of dialysis social workers or medical social workers in general (Dane & Chachkes, 2001), specifically pertaining to work-related

stress. The stories of dialysis social workers are never told individually, but with other professional key informants such as nurses and dialysis technicians on the dialysis unit. An example of this is the Bohmert, Kuhnert, and Nienhaus study (2011), the most recent descriptive systemic review project that explores stress on a dialysis unit by examining articles about various professionals involved in dialysis treatment. The research questions used in the present study are designed to uncover how social workers really feel about their work. Currently, there are scant data regarding how dialysis unit social workers are perceiving stressors such as supervision issues, organizational factors (Boscarino et al., 2004; Ortlepp & Friedman, 2002), work schedules, and other unit duties (Creamer & Liddle, 2005). Qualitative inquiry might capture the voice of the dialysis social worker; specifically, the thoughts, feelings, and views that construct the perception of work-related stress. The data may help the social science community understand both the motivational and impeding character of stress.

## CHAPTER 3: METHODOLOGY

### Purpose of Study

The purpose of the present qualitative study is to understand characteristics and commonalities among dialysis social workers. The study examines the social workers' perceptions of work-related stressors. Social constructivist theory is used as a conceptual framework to analyze the responses from the sample. The validity of the methodology was tested via qualitative pilot study conducted during a supervised student project in 2009. A new theoretical understanding about work-related stressors and stress evolved from the study. Data collection is guided by grounded theory (Charmaz, 2006; Glaser, 1978; Glaser & Strauss, 1967; Strauss, 1987).

#### Research Question(s)

The primary research question of this study is:

*What aspects of dialysis social work are identified as stressful?*

The sub-questions are

*How does stress affect the quality of dialysis social work practice? and,*

*What coping mechanisms and sources of social support exist that assist dialysis social workers to manage workplace stress?*

The analytical question of this dissertation was:

*What skills, tools, or services are needed to assist dialysis social workers in managing work-related stress?*

### Subject Population and Recruitment

I recruited a sample of 12 (N=12) dialysis social workers using a purposive sampling technique (Rubin & Babbie, 2008). The purposive method of recruitment was

used in order to locate social workers who work in dialysis units. Purposive sampling is also referred to as judgmental sampling because the subjects are selected based on the researcher's knowledge of the study population and the principle purpose of the study (Monette, Sullivan, & Dejong, 2008). Judgmental sampling is helpful when researchers need to reach a specific sample with special characteristics (Rubin & Babbie, 2008). I used local social work networking events, such as university functions, conferences, and symposium to recruit subjects.

I placed computer-based advertisements on several websites: Facebook, LinkedIn, and Twitter to support the "word of mouth" recruitment of respondents. The advertisements encouraged all potential subjects to invite their colleagues to participate. I assigned all subjects a number between 1 to 12 to track their information throughout the study. I also used this procedure to keep the identities of the participants anonymous and confidential.

I recruited 12 subjects for this qualitative research study. A small number of participants was appropriate in this study due to the nature of the research objective. According to Morse (2000), a researcher can estimate a number of participants required to reach saturation based on factors such as the scope of the study, the nature of the topic, the quality of the data, and the type of study design. As stated in the literature review, stress is a topic that is identifiable by most social workers; thus it will be quite possible to observe commonalities among the subjects' responses in a small number of interviews.

### **Inclusion Criteria**

Each of the 12 subjects was assigned to an independently owned and operated dialysis center or hospital based dialysis unit. In order to gain information about the

individual social worker's experience and knowledge of the dialysis unit as an organizational system, the subjects were required to have at least six months of work experience at their current work site. This specific criterion insured that the subjects had been exposed to dialysis work related stressors for at least six months. The subjects were all graduates of an accredited school of social work or met the educational requirements of the state of employment to serve as a dialysis social worker. The interviewees identified as either male or female.

### **Human Subject Protection**

This study began after receiving approval by the dissertation committee and the University of Pennsylvania Institutional Review Board (IRB). I followed the formulated guidelines of the University of Pennsylvania IRB and performed all safeguards to ensure that the subjects involved in this study were protected from physical and/or psychological harm. The subjects were informed of their right to volunteer or not to volunteer for the research project and verbally consented to the interview. I made provisions to insure confidentiality. On the consent form, there was a "highlighted check off clause" that allowed the respondents to indicate verbally to me if they would like to leave their phone number for future contact in case questions regarding their answers arise. The subjects verbally consented to be contacted again if any questions or clarification is needed. This clause protected the subjects' confidentiality and right not to be contacted again by me. I also included the "consent to be contacted" item to prevent the subjects from receiving any unwanted/unsolicited phone calls. I read aloud the consent form at the beginning of the semi-structured interview process in order for the respondent to be aware of all rights, aspects, and levels of participation involved in the study. Subjects

verbally consented to on audiotaped and not signed in-person in accordance with the requests of IRB.

Total participation of each participant in the study did not exceed two and a half hours. I followed the formulated guidelines of the University of Pennsylvania IRB. A member of the standing faculty of the University of Pennsylvania served as the “principal investigator” for this study. The principal investigator also served as the dissertation committee’s first reader. I adhered to the Code of Ethics of the NASW.

### **Incentives**

I did not provide monetary or gift incentives for participation. Professional responsibility and support of a doctoral-level graduate student served as the benefits of participating in this study.

### **Data Collection**

I used a focused interview approach. The focused interview offered the opportunity to conduct a thorough investigation of the common experiences of dialysis social work and their experiences with stress in the workplace. Qualitative research involves the systematic collection, organization and interpretation of data derived from discussions, interviews, and/ or observations (Malterud, 2001). A qualitative study is appropriate to highlight perceptions of social workers who work with high risk patients, such as dialysands. Many qualitative studies are conducted within the health care community. Research findings of the studies are often used to improve public health and to decrease disparities in health care access and delivery (Sandelowski, 2004). Glaser and Strauss (1967) developed grounded theory methods in the late 1960s in order to legitimize qualitative research as a credible form of inquiry (Charmaz, 2006). The

following steps are the components of grounded theory (Glaser & Strauss, 1967; Glaser, 1978; Strauss, 1987, in Charmaz, 2006, pgs. 5-6):

- 1) Simultaneous involvement in data collection and analysis;
- 2) Constructing analytic codes and categories from data, not from preconceived logically deduced hypotheses;
- 3) Using the constant comparative method- which involves drawing on comparisons during each stage of the analysis;
- 4) Advancing theory development during each step of data collection and analysis;
- 5) Memo-writing to elaborate categories, specify their properties, define relationships between categories, and identify gaps;
- 6) Sampling aimed toward theory construction, not for population representativeness; and,
- 7) Conducting the literature review after developing an independent analysis.

I used a semi-structured, in-depth interview process to collect data from 12 dialysis unit social workers who are employed by dialysis centers/units in the United States. The participants had the freedom to voice their worldviews (Liamputtong, 2007). I tape-recorded all interviews using a hand-held recording device. I conducted the interviews in-person at a neutral site, which did not include the participant's home or place of employment. Participants lived in New York, Northern Connecticut, New Jersey, Delaware, or Eastern Pennsylvania and traveled to meet me in order to conduct the in-person interview. Each social worker revealed how he or she perceived his or her

experience with work-related stress. I transcribed each interview, categorized by themes, and coded with the assistance of a volunteer second coder.

### **Data Analysis**

I analyzed the responses and performed coding guided by grounded theory (Glaser, 1978; Strauss, 1987, in Charmaz, 2006). I performed first level (open coding), second level (abstract), and third level (theoretical) coding to analyze concepts and arrive at broader levels of code categories to obtain a thorough understanding of the themes evolving from the data (Schreiber & Stern, 2001). I analyzed and reviewed the third level coding to verify if a possible new theoretical concept about work-related stress evolved from the themes and commonalities revealed in the respondents' answers. I then used theoretical sampling to analyze the meaning of the thematic categories, discover variation within the different categories, and then define the gaps among the various categories (Charmaz, 2006).

I used social constructivist theory to categorize the common themes or “constructs” in the responses provided by the participants. I performed the primary coding. Trained volunteers performed the secondary and tertiary coding. We continued the thematic coding until theoretical saturation or informational redundancy (Onwuegbuzie & Leech, 2007) was observed in the voices of the key informants. I used the MAXQDA 11 (1989) qualitative analysis software to track, organize, and arrange data for coding. The MAXQDA 11 (1989) system was very useful in organizing the parent codes and sub-codes as well as generating memos. I examined the data to evaluate if dialysis social workers are stressed by the system. I report the results in the Chapters 4 and 5.

### **Reflexivity Statement**

I was employed as a social worker for the past 13 years and has had six years of experience working with dialysis patients as an emergency room social worker.

Reflexivity may influence the review of the subject's responses and coding portion of the study. I remained objective throughout the duration of the study. I kept a field journal, that helped to alleviate any level of personal bias and views from becoming a part of the study's outcome.

### **Risks and Benefits of Subject Participation**

There was little harm or risk to potential subjects of this study. One potential risk factor was that the subjects may have become more aware of their professional stress during their participation in the course of the interviews. The subjects' responses uncovered feelings and a new sense of awareness of their professional issues and concerns. The potential risk was also a possible benefit of participating in the study. The subjects may have ascended to a new level of insight and self-awareness, which may benefit their clinical practice and professional interactions on the dialysis unit. Subject #3 stated that the interview process made him aware of his coping skills, especially when dealing with client deaths on the unit.

## **CHAPTER 4: FINDINGS**

### **Description of Sample**

The following are the demographics of the study population of the study. The sample consisted of 12 subjects who were recruited through social media (LinkedIn, Facebook, and organizational list serves of local NASW chapters) and snowball sampling. Ten of the subjects were from New York and two were from Pennsylvania., No social workers responded to recruitment efforts from Connecticut, New Jersey, or Delaware, despite diligent recruitment efforts and assistance from local social work organizations. Three subjects were African-American females. Six were Caucasian females, and three were Caucasian males.

During the recruitment phase, I found that Hispanic, Asian, and African-American dialysis social workers were hesitant to participant. In the course of the screening phone call, minority social workers stated that they were concerned about how participation in the study would impact their current employment. The model age of participants in this study was age 46 (see Tables 1 and 2),. Two subjects were similar, both were age 46, single, no children, and dedicated to dialysis social work practice. The subjects stated they were workaholics. The mean of participants was 47.75 years-old and the median age was 47.1. The youngest participant was age 24 and a new graduate; the most senior participant was age 64 and preparing for retirement. In regards to conditional variables, Subject 6 was hearing impaired and Subject 12 was pregnant. During the interview process, I used special procedures to accommodate the hearing-impaired participant, allowing him to read along with the interview questions as they were read

aloud by the interviewer. Subject 12 was pregnant, and she was afforded personal breaks during the interview to accommodate her special needs.

Table 1. *Demographics of subjects 1-12 N=12*

<b>Subject Number</b>	<b>Age</b>	<b>Gender</b>	<b>Race</b>	<b>Experience</b>
1	46	Female	African American	▪ 22 years of Dialysis Social Work Practice
2	24	Female	Caucasian	▪ 1 year of Social Work Employment ▪ 6 months of Dialysis Social Work Practice New Graduate
3	54	Male	Caucasian	▪ 19 years of Social Work ▪ 10 Years of Dialysis Social Work Practice
4	58	Female	Caucasian	▪ 12 years of Social Work Practice ▪ 2 years of Dialysis Social Work
5	46	Female	African American	▪ 24 years of Social Work ▪ 5 years of Social Work Practice
6	64	Male	Caucasian	▪ 30 years of Dialysis Social Work Practice
7	32	Female	Caucasian	▪ 5 years of Social Work ▪ 1 year of Dialysis Social Work ▪ Recent Graduate
8	60	Female	Caucasian	▪ 42 years of Social Work ▪ 35 years of Dialysis Social Work
9	49	Female	Caucasian	▪ 18 years of Dialysis Social Work Practice
10	42	Male	Caucasian	▪ 17 years of Social Work ▪ 5 years of Dialysis Social Work Practice
11	61	Female	Caucasian	▪ 31 years of Social Work ▪ 9 years of Dialysis Social Work Practice
12	37	Female	African American	▪ 12 Years of Social Work ▪ 9 years of Dialysis Social Work Practice

Table 2. *Descriptive Demographics of Sample N=12*

<b>Age</b>	
Mean	47.75
Mode	46
Median	47.1
<b>Gender</b>	
Female	9
Male	3
<b>Ethnicity</b>	
African American	3 females
Caucasian	6 females 3 males
<b>Age Range</b>	
Youngest	24
Oldest	40
<b>Location</b>	
Pennsylvania	2
New York	10
<b>Conditional Variables</b>	
Hearing Impairment	
Pregnancy	
<b>Years of Social Work Practice</b>	
Mode	12
Median	18.1
Range	41
Mean	19.42
<b>Years of Dialysis Practice</b>	
Modes	5 and 9
Median	9
Range	34.5
Mean	12.21

There are two major findings regarding the perceptions of stress of dialysis workers: the first was job flexibility; and, the second was work commitment. These two

themes appear to be perceptions and values shared among the dialysis social work community.

### **Job Flexibility**

Dialysis social workers report job flexibility. Three of the participants shared their thoughts on the flexibility of dialysis social work, specifically the convenience of having flexible weekly work schedules. It appears as if job flexibility is perceived as a work benefit, which helps to alleviate work stress. Subject 1 said:

*I have been employed at my worksite for over 20 years. I have flexible hours, which is a very attractive feature of my job. My clinical manager trusts me, I have a great deal of autonomy at the center where I am employed due to my length of employment and level of commitment.*

Subject 3 indicated, “I work part-time at two different dialysis sites within the same community, which is very convenient for me.”

Subject 12 shared:

*I work four days a week, which is extremely convenient for me since I have small children. The flexibility of our schedules is an incentive not often found in other fields of social work. I seldom have to call out sick because I am able to take care of all of my personal business on my days off.*

### **Work Commitment**

The participants reported a strong sense of obligation to be present for their clients, which may have had an impact on their perception of job commitment and work longevity. Most of the study respondents worked in dialysis social work practice for more than 15 years. Even though respondents describe the daily obstacles and challenges on the unit as a “roller coaster,” most stated that they enjoy their work and find it fulfilling. Subject 1 said, “I am a self-proclaimed workaholic. Matter of fact, I am going back to work after this interview, even though it’s after 5 pm!”

Subject 5 stated, “Most days are good days. No matter how frustrating, there is always something good/positive, I am staying optimistic. I never have a horrible day since I am accomplishing one professional goal a day.”

Subject 6 shared,

*At the last dialysis center where I was employed, I had a key to the center and would go in on the weekends to complete paper work. I worked so hard and it had a negative impact on my personal relationships, it irritated my wife.*

Subject 7 asserted, “Our work is rewarding; good client contact, many creative ways to work with clients, general counseling, this job makes you more conscious of your own health.”

Subject 10 shared, “My supervisor and co-worker are very supportive; I usually receive whatever assistance I need to meet my professional goals as well as to take personal time out for myself within reasonable limits.”

Respondents identified professional support given by administrators, unit social workers, and other dialysis care professionals as a valued coping mechanism for dialysis social workers. Respondents discussed how the unit dietician was a confidante in the workplace during times of crisis and angst. The dietician often serves as a compassionate listener who empathetically aids in promoting a sense or perception of professional peace. The participants stated that the support provided by their unit dietician often helped them cope with stressful situations such as the death of a client, conflicts with other staff members, supervisors, and/or clients. The unit dietician serves as a peer and colleague who also understands the plight of an allied health care professional whose work may not be valued the same as other health care professionals in the dialysis setting. The subjects revealed their perceived importance of this professional bond in regards to managing work-related stress. Subjects 2, 3, 7, 8, and 9 spoke of the high level of

professional support they receive from administrators, the dialysis dietician, and other staff members:

Subject 2 indicated:

*I had an issue with a high level administrator –my supervisor helped me through it. She intervened on my behalf which helped me alleviate the problem. I was feeling very overworked, she told me that nurses should be doing some of my duties. Nurses tend to dump work and beat up on social workers. I have a strong connection with the unit dietician. I am usually able to seek out informal support from the dietician and clinical nurse manager.*

Subject 3 stated:

*I receive professional support from my administrators 80% of the time. I try not to focus on the other 20% (when I feel a lack of support) because I receive support most of the time. I feel the most supported when my supervisor knows I have a lot of work and have to multi-task. I feel the least support when my supervisors feel stressed out by their upper management. When something goes wrong, my administrators are very expressive about me correcting it immediately. My colleagues (specifically the dietician and clinical nurse manager) are my main sources of informal support (on the unit). I often share my thoughts while eating lunch. We don't have formal administrative support to discuss provocative issues such as client deaths. The informal support really helps me to cope in difficult times.*

Subject 7 stated, “I work very closely with the clinical nurse manager and dietician. They are very supportive and help me cope.”

Subject 8 said:

*The dietician and the other social worker on the unit are a huge support. When time allows, the three of us meet to vent and support one another, especially after a rough day/experience. Sometimes all of the difficult days feel as if they are blent together. Summer can be very difficult (Probe: Why are summers more difficult? The heat, patients going on summer vacation, especially those who travel without preparation/prior notice, more issues overall seem to come up during the summer). Though it is challenging, in dialysis social work, you have the opportunity to have long standing relationships. The staff here is very collegial.*

Subject 9 shared “The other social worker on the unit is my support. The administration is as supportive as they can be in a corporate dialysis setting like this.

Every week we have an informal interdisciplinary meeting-the interdisciplinary team is very supportive.”

### **Other Significant Findings**

#### **Paperwork and Administering the KDQOL-36**

Most of the participants stated that there is an overwhelming amount of paperwork in dialysis social work practice due to the numerous reports required by the various federal agencies such as IPRO (Island Peer Review Organization), Centers for Medicare & Medicaid Services (CMS), and Department of Health (DOH). IPRO is an accredited independent review organization that assesses the quality, safety, and medical necessity of care (IPRO, 2014). IPRO is a “peer-review organization in New York State that functions under a contract with the Health Care Financing Administration of the US. Department of Health and Human Services for assuring quality of care for Medicare” (Nenner et al, 1995, p. 59). IPRO also evaluates the appropriateness of decision making by practitioners and agencies in healthcare. The CMS is an agency under the auspices of the U.S. Department of Health and Human Services responsible for administration of various key federal healthcare programs such as Medicare, Medicaid, CHIP (Children’s Health Insurance Program), the Health Insurance Portability and Accountability Act (HIPAA), the Clinical Laboratory Improvement Amendments (CLIA) and other services (CMS.gov, 2014). The major goal of CMS is to aim for a higher quality of national healthcare at lower costs. Dialysis social workers have to submit frequent and timely reports to both the local and federal levels of the DOH. The U.S. Department of Health and Human Services aims to protect the health of all Americans, provides essential human services, and special services for those who are least able to care for themselves

(HHS.gov, 2014). The subjects were able to expound on the rigors of their paper work routine:

Subject 3 said:

*I feel stressed in regards to referrals/administrative responsibilities. We have to complete weekly and/or monthly reports to CMS Medicaid in regards to the monitoring and tracking of attrition rates, deaths and transfers. I also report clinical information to doctors, dieticians, community person/representative and network community outreach reporting. I've adapted but I do feel branched out at times due to multi-tasking. I have a small caseload now; I see about 60 patients during the three days I work part-time in the center.*

Subject 4 indicated

*There is a lot of paperwork, I had a caseload of 52 clients now I have 37 clients. There is a decrease in my patient census due to the selling and privatization of the dialysis unit. I have many clients on my caseload who are uninsured and undocumented. I prefer outpatient to inpatient work. I divide my week into patient care days, Tuesdays and Thursdays and my paperwork days are Mondays, Wednesdays, and Fridays.*

Subject 5 said

*Lack of organization can be stressful so I have my own personal system for paperwork. I have a caseload of 75 clients. I do quarterly notes. I supervise two other social workers. I insure that notes are completed the first and second week of the month. I look at paperwork as something that I have to do.*

Subject 6 asserted, “Besides the routine paperwork, we also have to participate in webinars and read an inordinate amount of e-mails because things change so often, one has to keep abreast of new information daily.”

Subject 8 shared

*I sometimes come in on the weekends to complete my paperwork. Meeting mandates is a huge obstacle in dialysis social work. I feel pulled in many directions. I'd rather be out doing patient care. I put out fires, it's hard to balance. I follow protocols and I feel overworked. You ask yourself are you contributing to the patient's overall quality of life. As a fulltime social worker, I share a caseload of 160 patients, 8 receiving in-home dialysis and 4 receiving peritoneal dialysis patients with a part-time social worker.*

Subject 12 said, “I multi-task a great deal, there are deadlines on top of deadlines, everything is due at the same time. The most stressful aspect of paperwork for me is obtaining insurance authorizations.”

In regards to the KDQOL 36, participants stated that administering the survey isn’t stressful, but the act of having the client return it and meeting the 90-day deadline for a large caseload is stressful. Subject 1 stated, “The KDQOL-36 is just another task for me to do.”

Subject 2 said,

*You can hand it to the client or you can sit with them if the client wants, especially with older clients. I find it very useful. I actually like administering it. The only stressful thing is that patients don’t bring it in.*

Subject 3 stated,

*I am always behind, I think all of my colleagues are behind in paperwork. I actually like doing the KDQOL-36. It is a challenge if the patient doesn’t speak English. It’s available in Spanish and Creole Languages. One of the clients complained that it was poorly translated into Creole. Another stressful aspect is if their scores aren’t improving. The point of the survey is to evaluate how they are improving on dialysis and provide data back to the patient. The implementation isn’t always helpful. Sometimes patients don’t return it.*

Subject 4 said, “It’s basically a client-action plan, I find it useful, not stressful.

The stress comes in asking to do it and to have it returned.”

Subject 5 shared, “No stress. 90 days to do the survey, then thereafter it’s conducted on an annual basis it is a bible, it is a tool. CMS is looking at mandating it.”

Subject 6 asserted

*The KDQOL-36 isn’t difficult to administer. It’s based on the University of Arizona study in which 1,500 dialysis patients measure quality of life/coping with dialysis in relation to other patients. The dialysis social worker has to enter the client responses into the program-score and patient summary. It’s a lot of paper work in combination with the CIA Comprehensive Integrated Assessment, which is the 30-day initial assessment from the doctor, nurses, social worker and*

*dietician, the plan of care, which is seventeen pages. It's a lot of paperwork during the first 90 days.*

Subject 7 said, "The KDQOL-36 is just another thing to be done. It's the lowest level of stress for me."

Subject 8 said, "The stressful aspect of it is that patient's don't always return it and when many of them are due at the same time."

Subject 9 asserted

*Not sure why it exists. I know it is a survey. I explain that it is not mandatory. There are questions such as how often do you experience pain? The client's answer may not have anything to do with dialysis. There are only yes or no answers. Yes I am sad because I just lost my husband not because of dialysis. Do I do it-yes, do I do it in a timely manner-no.*

Subject 10 said, "In regards to the KDQOL-36, my experience with stress is trying to complete it for every patient and having them return it. If you complete it with them, then it will be some bias."

Subject 11 shared,

*I like doing it. Patients are very optimistic when they describe their health. I obtain a better idea of what they are going through. The scoring takes time, then I have to write a progress note and update the psychosocial. It keeps my nose in the paperwork and not on my paperwork. They replaced a one-page assessment with the 15 page KDQOL-36.*

Subject 12 said, "I have the client sign a consent, I then give a description of the survey. The most stressful aspect is having the client return it."

### **When Support Is Not Enough**

Two of the respondents stated that they had to seek out professional care to deal with the effects of professional stress and its outcomes. Subject #6 discussed his experience in receiving professional help (psychotherapy) to address his exposure to professional stress:

*Working with one client feels like a full time job. I was once blamed for something that went wrong while I was on vacation. I felt like I was going to have a breakdown. I attended counseling from 1980-1983. My therapist encouraged me to leave my job. I still went to work despite the stress. I had to pay bills and a mortgage. The therapist warned that I was on the edge of a breakdown. I resigned and felt better. (At this point of the interview, the subject paused and rubbed his eyes).*

Subject 7 shared during the interview that s/he had to address the physical outcomes of exposure to stress:

*Sometimes I feel as if there is 'not enough me, not enough time'. I went to my medical doctor because I started having physical signs of anxiety and work stress. This type of work encourages you to become more conscious of your own health.*

### **Client Death as a Stressor**

Client death was identified as a professional stressor by all of the participants.

Also, three of the subjects stated they had to take time off from work in order to cope with client deaths:

Subject 1 observed

*Client deaths are always difficult because we spend more time with our clients due to weekly dialysis treatment than we do with our own families. There is a lot of death and dying. This part of the job is very stressful. It is hard to cope with death at work and maintain professional boundaries.*

Subject 2 shared

*Three months after I began working at the center, a middle aged dialysis patient who recently began treatment committed suicide. The patient was very resistant and refused social work services. That experience changed my perspective. It is very hard being a new MSW/SW, I blamed myself, wished I could have saved the client. I do have a day off once in a while, but in order to deal with this tragedy, I took many days off, I felt like resigning. This position can be overwhelming because you always have to do more than one task at a time. I had to take some personal time off to regroup after that experience.*

Subject 3 said

*I would say there is a fairly high amount of depression in dialysis patients due to the many medical complications which led to dialysis treatment. I've experienced one client suicide. One dialysis patient admitted that he was very depressed due*

*to being on dialysis. We offered him counseling and hospitalization. He refused. He was very isolated. A couple of weeks later he committed suicide. It was hard. I asked myself if it was more I could have done. We deal with a high level of mortality.*

Subject 4 said, “I had to take some time off to be with my family because my two favorite patients died. Deaths which occur over the weekend are the hardest.”

Subject 5 stated,

*I had to take some mental health days off due to experiencing three client deaths in a row. Here on Monday, gone on Wednesday. They often have complications after transplants, massive heart attacks and coronaries, child deaths are always hard. God took home an angel. Deaths are always hard.*

Subject 6 said, “I had a client who decided to terminate dialysis treatment, went on vacation, and never returned. It is also difficult when patients have cancer and are undergoing dialysis.”

Subject 7 observed

*I take comfort in knowing that the client will be in a better place. Client deaths are easier to stomach when it's an older client/someone who has been sick. My two favorite clients died. Deaths which occur over the weekend are the hardest.*

Subject 8 said,

*We had a young woman with very young children, was noncompliant, missed weeks of treatment, letters were sent as reminders, she died due to noncompliance. We often see what they don't. We also had a patient, age 35, who returned from vacation, told us the Lord told him he will be healed. He was de-compensating-his wife supported him, he stopped dialysis treatment and died. The wife was beside herself at the funeral. She really thought he was going to be okay. We have another client dying of cancer, very difficult to watch.*

Subject 9 asserted, “It's not stressful, it's sad. There were patients here who bled out. People have coded, can't breathe, even the medical examiner was here.”

Subject 10 indicated, “I work with adults and children on dialysis. Child deaths are always hard. Losing a client is very hard.”

Subject 11 shared “I love my work, it can be very depressing. The clients are very inspirational. They go through a lot of loss, amputations/health issues...and they keep smiling.”

Subject 12 said,

*On my first day of employment here, a patient coded on the machine, it was all hands on deck. I had to call the family. This was my first week at work, I called the family and gave them the basic information. I cried, I cried.*

These statements were consistent with the findings in current literature regarding exposure to work-related stress, especially traumatic experiences such as client death. Current research also suggests that exposure to work-related stress impacts work attendance. Poor work attendance/high absenteeism rates (Dane & Chachkes, 2001; Grassi & Magnani, 2000; Elloy, Terpening, & Kohls, 2001) and job turnover (Cyphers, 2001; Kim & Stoner, 2009; Lloyd, King, & Chenowith, 2002); Mor Barak , Nissly, & Levin, 2001) are often behaviors and consequences found in those who work in social services as a result of exposure to work-related stressors. The subjects were not able to correlate taking off “mental health days” to grieve as a way of coping with work-related stress as described in literature. The subjects did not consider this form of absenteeism to be an outcome of compassion fatigue, burnout, or secondary trauma. All of the respondents denied experiencing poor work attendance or frequent absenteeism when asked how stress may impact job attendance.

### **Difficult Patients as a Stressor**

As cited in current literature (Bourassa, 2008), social workers often have to deal with client’s who display difficult behavior. Subject 6 discussed the volatile “tough clientele” of his dialysis site. The respondent stated that he felt like a “*police officer*” at his work site. He described a client who would take her physical pain out on staff; she

would actually physically attack and “*claw staff members.*” He mentioned that quite often his site would have to use Federal Law 494.70 and 494.180 (Federal Register, 2008), which allows 30-day notice to remove disruptive patients from the dialysis center. The social worker/interdisciplinary team members are required by Federal law and Medicare regulations to notify the State DOH, IPRO Network, and the patient in writing of the site transfer or removal due to violent behavior that may place others in the dialysis center at risk.

He also reported an incident where one of his colleagues experienced an “*emotional breakdown*” on the unit after being exposed to two months of fighting between clients and staff. From his experience of over 30 years of dialysis social work practice, he stated that “*client threats are a common experience on the dialysis unit.*” These situations made him feel like a “*peacemaker/protector*” on the unit.

Subject 6 recommended walking away when clients are “*angry, volatile, provocative, or abusive.*” During his career, he also experienced clients bringing attorneys and friends to initiate internal investigations, discussions, and arguments with the interdisciplinary team about their concerns. He also experienced dealing with patients who were mentally ill/paranoid with a history of behavior issues.

Subject 5 shared his experience working with clients who appear “*unbalanced*” due to their difficulty coping with dialysis treatment and kidney failure. He suggested that dialysis unit managers be “*stern*” in order to protect clients and staff. He asserted that establishing trust is even more difficult when clients use “*harsh words like hand grenades.*” Clients have used phrases such as “*I’m going to make a complaint, you’re not*

*professional, and I'm reporting you."* Subject #12 stated that the biggest challenge was working with various personalities:

*The biggest challenge is working with different types of personalities and setting boundaries to prevent patients taking advantage constant interruptions when interacting with clients. There is a sense of physical danger due to a client's emotional state-their reactions are a concern of mine.*

### **Sense of Entitlement**

Many of the participants shared their feelings about a concept in practice they referred to as a client's "sense of entitlement." Most of the social workers in the present study defined this concept as the client's personal ideas of what he or she is entitled to as a patient undergoing dialysis care. This concept can be very challenging due to high patient caseloads and hefty paperwork.

Subject 1 stated

*There is a strong sense of what's called 'patient entitlement' observed in dialysis work practice. The patients are in a great deal of pain, they are angry, and feel as if the world is against them. Many of our patients have limited resources and have a great deal of socioeconomic care needs. It's a heavy strain on us as practitioners due to this poor economy.*

Subject 2 said

*I notice a sense of entitlement, especially in working with my clients who live in the urban areas as opposed to my clients who reside in the rural area, especially regarding issues such as transportation services. Some clients feel that they shouldn't pay anything for healthcare because they are on dialysis. It's a new mentality –some of the clients don't wish to pay co-payments, if they are really demanding, the often want everything involved in their treatment for free. I had a client who once stated 'I deserve that'.*

Subject 5 shared, “I call it instant gratification. Overtime, you learn how to deal with patient demands. The social worker must set boundaries in order to deal with a patient’s sense of entitlement.”

Subject 6 observed

*This job can be very stressful. Patients use their dialysis as a weapon, if they don’t get their way, they complain. I once had a client who requested a letter for traffic court, the rationale being, he should be excused for speeding because he is on dialysis. Sometimes as a fulltime social worker, you are dealing with a ratio of one social worker to 145 patients. You have to be aware of your use of self in order to cope with the high level of patient needs.*

Subject 7 suggested

*There is a sense of entitlement in dialysis social work due to the client’s lack of understanding of how insurance companies work. I wish I received more information or a course while studying for my MSW about how to be a better advocate when accessing a client’s insurance for services.*

### **Patients in Denial**

Many of the respondents discussed their perceptions of stress working with clients who are in denial.

Subject 2 shared “There is professional stress from denial and resistance from both the staff and patients. More noncompliance observed in this type of work than in other fields of social work.”

Subject 5 reported difficulty engaging clients after they declared “*there was nothing wrong with them.*” Patients tend to have “*unreasonable hope;*” the patients mistakenly believes their kidneys will function again and they can fully recover.

Subject 7 discussed the difficulty of working with a client’s denial when it is compounded by the gravity of the family’s denial: “*It is important to be aware of a*

*patient's concerns and feelings, especially when both the patient and family members are not ready to deal with the issue of death."*

Subject 9 offered that it was difficult to empower clients due to their "*tremendous sense of loss, mourning their past lives due to being unable to do the things they used to enjoy.*" Subject 9 also stated helping patients cope with denial makes her feel "like a parent sometimes" because of the time consumption and demand:

*You see what they don't or how you would see a child. I know best. You almost feel like you are the parent teaching the child...so many challenges to this job. You got into this profession because you want to make a difference. If you don't feel that way, why would you stay? I've come in at 5am in the morning to see a patient about a personal issue. Veterinary Social Work Practice has got to be better!! It is stressful when a client is having a crisis and the rest of the community is in crisis. You have 90-year-old people who refuse to give up their driver's licenses. We have to make this into a reality show.*

### **Lack of Professional Respect**

Another commonality shared by most of the respondents was the perception of support by their interdisciplinary team and colleagues but a lack of professional respect from both clients and staff. Subject 8 identified role ambiguity in dialysis social work to be a prevalent stressor, which lends to dishonoring and disrespecting the role of the unit social worker. Her monologue revealed her perception of feeling:

*"unrecognized because most people don't understand what social workers do and are unaware that social workers hold Master degrees and are licensed professionals. Our salaries also are an indication of the lack of professional respect we endure."*

Subject 2 said, "People don't see the importance of social work-there is a lot of resistance, especially from professionals who don't understand what you are doing. Other staff members don't always know what social workers do."

Subjects 2 and 6 both indicated "there is a huge difference between what social workers are trained to do and what dialysis social workers are actually doing in the field."

Subject 6 observed barriers such as the lack of privacy to interact with dialysands, competing with an awesome level of noise mainly from the dialysis machines, the nurses and other staff members working on the unit, as well as other constant interruptions such as televisions watched by clients during their treatments have a huge impact on the respect level of dialysis social workers who have to deal with these work conditions.

Subject 9 asked

*How do you quantify what we (dialysis social workers) do? You are labeled a bad social worker if you don't give into client and staff demands. Anyone who says they want to be a social worker, I talk them out of it. I TALK THEM OUT OF IT-SAY THEY ARE CRAZY. I don't know one social worker who has one job and can support themselves and we have graduate degrees. For what your education costs, it does not reward you. It makes you feel good but, it doesn't pay your bills. My sister is 8 years younger, straight out of the gate, she made twice what I made. The profession isn't regarded high, they think we are gophers. Then there are people who call themselves SOCIAL WORKERS, who don't have the education. It is a poor return on your investment. I am not a member of NASW. I don't think they do enough to advocate for social workers.*

Subject 11 stated, "My supervisor is a nurse-she just doesn't get it. They (the administrators) don't want you to hear when they have a compliment. They act as if they don't want to spoil you."

### **Threatening to Quit**

Work-related stress has a direct impact on job turnover in social work practice (Cyphers, 2001; Kim & Stoner, 2009; Lloyd, King & Chenowith, 2002; Mor Barak, Nissly, & Levin, 2001). I asked the study participants if they ever threatened to quit. All of the participants stated that at least once during their job tenure, they had at least thought about threatening to quit. However, only a few of the participants have ever taken action towards quitting or have actually quit:

Subject 1 shared, “I actually wrote a letter to my unit manager stating that I was terminating my position. I walked around with the letter for a week...and then destroyed it. This occurred during a very rough week at work.”

Subject 2 said, “There have been several days when I felt like resigning, but after speaking with my corporate social worker, I feel supported and continue to stay.”

Subject 3 noted “I say *I quit* to myself at times—well everyday—but I don’t. I have fairly good support.”

Subject 4 said, “I threatened to quit five times, but my spouse and my co-worker talked me out of it.”

Subject 5 indicated, “I thought about quitting every other day when I experienced the three client deaths in the same month this year, but I didn’t quit.”

Subject 6 said, “At this current job site, I thought about quitting due to the job politics. What else can you do? You have no choice but to cope.”

Subject 7 said, “Yes, I have wanted to quit; but, I have a supportive supervisor with whom I can talk to and discuss my concerns.”

Subject 8 shared, “I have never threatened to quit. I will stay until I retire.”

Subject 9 said, “I have never threatened to quit. I have a 14-year-old and an 82-year-old father to care for...money is a factor.”

Subject 10 shared, “I have never threatened to quit. The first three years of my employment was during the recession, so I have never threatened to quit.”

Subject 11 said, “I have threatened to quit, but the senior clerk here is a good friend who is very supportive; after talking with her, I no longer felt like quitting.”

Subject 12 indicated, “At my other job, I quit and I did it right on the spot. I gave one month’s notice.”

The responses in this section speak to the high level of work commitment that evolved as a significant theme in this study.

### **Situational Stressors**

#### **Hurricane Sandy**

On October 29, 2012, Hurricane Sandy (also known as Superstorm Sandy) was the largest hurricane ever recorded in history on the northeastern coast of the U.S. (Schrieber, Lin, Omaish & Broderick, 2013). The storm was the deadliest and most destructive hurricane of the 2012 Hurricane Season (United States National Oceanic and Atmospheric Administration’s National Weather Service, May 2013). About 233 people lost their lives in the storm in eight countries and the U.S. alone suffered \$65 billion in damages (Diakakis et al., 2015).

The experiences were still vividly fresh one year later and in the minds of the subjects. New York City and other coastal areas experienced severe flooding and wind damage. Thousands of New York City residents were evacuated and were led to homes of family, friends, local shelters, and alternative medical facilities (Schrieber, Lin, Omaish & Broderick, 2013). There was a loss of electricity, heat, and gasoline. Forty-three New York City residents perished within the five boroughs and 14 residents died on Long Island (Schrieber, Lin, Omaish & Broderick, 2013).

Three of the respondents, namely Subjects 3, 8 and 9, were employed by dialysis centers that were affected by Hurricane Sandy. The effects of Hurricane Sandy were also stressors identified by the respondents. These respondents worked in severely devastated

areas and offered detailed descriptions of the stress experienced in coordinating services for clients on their units and transitioning back to their regular dialysis units after being displaced for six months.

Subject #3 shared:

*Our facility was flooded during Hurricane Sandy. The dialysis center remained closed for six months until it was fully rebuilt. I recall staying later hours to accommodate patients receiving services during various shift schedules. Clients were transferred to various satellite dialysis sites which made commuting between the various sites a challenge for me. Clients were moved to hospitals/nursing homes. Our company had capacity to accept and temporarily transfer patients to other 'sister sites,' it had taken 6 months to return. The Hurricane Sandy experience strained relationships with clients, I had to work later hours. Patients were patiently staying for later shifts, most returned back to the site after Sandy. We have a brand new facility since it had to be rebuilt.*

Subjects 8 and 9 voluntarily drove clients to dialysis treatment due to transportation services being deeply impacted by Hurricane Sandy. The two subjects remembered being deeply concerned about the status of their elderly patients during the recovery period after the storm. They also mentioned the heroism of the dialysis staff members who slept at the dialysis center to insure availability of dialysis treatment.

### **Policy-Budget Sequestration 2013**

Several of the respondents discussed Budget Sequestration 2013 (Cowan & Young, et al., 2013; Rushe, 2013; Vergano, 2013; Washington Post, 2013). The term *sequestration* refers to the federal budget cuts of up to 12.4% of the dialysis care budget proposed for 2013 (Washington Post, 2013). Sequestration is the process that automatically cuts the federal budget affecting most departments and agencies (Whitehouse.gov, 2013). As per KCP, one of the nation's premier kidney care coalitions, the magnitude of the proposed cuts would mean a \$30 reduction per dialysis treatment (PR Newswire, 2013). Most of the respondents were concerned with how these proposed

budget cuts will impact health care and human services, more specifically, their client's welfare. Congress prevented the cuts by passing the American Taxpayer Relief Act on January 2, 2013. This law pushed the budget cuts back until March 1, 2013. The interview process for this study largely occurred during the government negotiations, which led up to the government shutdown also referred to as the 2013 furlough that lasted during the first two weeks of October 2013—a total of 16 days (Whitehouse.gov, 2013). The participants were concerned about how governmental actions would impact service delivery to clients. The respondents appeared to be knowledgeable about the possible future impact of these cuts on dialysis care.

Subject 2 asserted that “The federal government is attempting to cut 12% of the Medicare budget, which will drastically impact dialysis patients.”

Subject 5 said

*The biggest change has been with resources for daily survival such as medicinal and nutritional supplements. Patients are now required to obtain written permission from a physician in order for a pharmacist to charge Medicaid or Medicare for the Nepro Nutritional Supplement needed to treat low albumin levels. I am concerned—the new regulations for treatment for patients with low albumin levels can be detrimental to personal care. If written permission isn't granted by the physician, the patient will have to pay \$25.00 per case out of pocket for this supplement. This can be very expensive especially for a patient living on a limited income.*

Subject 6 said

*Commercial insurance is a gold mine and governmental insurance programs such as Medicaid and Veteran's Health benefits are perceived as a loss. The Government insurance plans namely, Veterans Healthcare, Medicaid, and Medicare now have strict reimbursement criterion for dialysis centers. The federal government is suggesting the concept of “bundling” packages to cover treatment and medications for dialysis patients.*

There will be even more of a lack/dearth of resources due to these federal cuts. The new guidelines will make Epogen treatments and Nepro Nutritional Supplements quite expensive if it isn't covered by insurance.

## **CHAPTER 5: CONCLUSION, DISCUSSION, AND AREAS FOR FUTURE RESEARCH**

With regards to coping with stressors, the two dominant themes that emerged in this study were job flexibility and work commitment. Dialysis social workers face significant stressors in their work, including, as they recount: a) the high rate of mortality and client death; b) heavy paperwork/large caseloads; c) the need to seek out support from peers/administrators; and, d) lack of professional respect; and e) patient denial.

These findings are consistent with the tenets of social constructivist theory (Assman, 2008; Cottone, 2007; Elkaim, 1990; Gergen, 1985; Held, 1995; Maturana & Vasela, 1992; Mead, 1934; Mo-Yee & Gilbert, 1999) that suggests that systems are both self-defining and self-managing. I gained an understanding of how dialysis social workers cope with the tremendous amount of stress involved in their daily practice. Their clients are ill with life-threatening diseases and high rates of death across the life span. Their clients are difficult and their biggest issue is non-compliance.

Like all social workers, dialysis social workers suffer from a lack of professional respect. Yet, dialysis social workers report a high level of work commitment. How do they construct a reality so that they remain committed to this line of work? What I discovered is that they use a support system comprised of peers and administrators as well as a deep commitment to the clients as a way of balancing the stressors. The work commitment may be the construct “my clients need me, I am so needed with the exception of a mental health day here & there, I overcome a difficult work situation.”

The reality they construct isn't a fantasy nor does it cover up the difficulties of the industry also experienced by peers and administrators. The stressors are the common

enemy that binds the workforce together and adds meaning to their life and work which leads to work commitment.

Support from peers and administrators appears to be a common denominator in the dialysis social work community that allows practitioners to cope, thrive, and exist in a turbulent field. Future research will be needed to further develop a theory regarding this concept. The commonality is consistent with the tenets of social constructivist theory (Assman, 2008; Cottone, 2007; Elkaim, 1990; Gergen, 1985; Held, 1995; Maturana & Vasela, 1992; Mead, 1934; Mo-Yee & Gilbert, 1999). Constructivists also purport that persons who share common perceptions, values, experiences, and ideas are connected by certain constructs and themes that are unique to their community. Peer and administrative support appear to be both shared professional values of importance and emotional survival in dialysis social work practice.

### **My Observations**

I began this journey of scientific inquiry six years ago because of my sincere interest in dialysis social work practice. As an emergency room social worker with 15 years work experience, I wondered how dialysis social workers coped with the daily rigors and issues that I experienced briefly in my interactions with dialysands who presented for care in the emergency room.

Dialysis social workers are exposed to physical hazards, exposure to blood pathogens and communicable diseases, the intense stress of helping clients deal with organ failure, co-morbidities, and a high risk of death. Their work is extremely stressful with grim moments.

The results of this research project show that although dialysis social workers experience stress and are exposed to various stressors at work, they are committed to their careers and clients. They appear to appreciate the flexibility found in their work assignments, which allows them to cope with their work-related stress.

The main goal of this project was to explore the stress in dialysis social work through the lens of a social constructivist. This perspective allowed me to take an ecological approach to examining the data provided by each participant using what Shulman (2009) refers to as the “person in situation” context. The perceptions of stress shared by the subjects illustrates that dialysis social workers are able to find meaning and a strong sense of purpose in their work. During the interview process, I became immersed in the subjects’ stories, which brought forth their ideas, thoughts, and perceptions of their professional stress.

Their perceptions ultimately connect dialysis unit social workers as a unique community and sub-culture with specific client-centered jargon, which is an important contextual construct. Transportation, insurance issues, patient denial, and non-compliance are specific challenges in dialysis social work. Dialysis social workers use specific jargon when discussing such issues, which is germane to their genre of work.

Subject 1 shared in her comments that she felt all too comfortable with the high level of stress involved in dialysis social work as a 20-plus-year seasoned professional. As with many of the respondents, I felt as if stress had become a permanent and expected aspect of her work which allows her to cope. I found this perception to be evident in the more experienced social workers. All of the participants appear to share a positive professional spirit, hope for change, and improvement, which is indemnified in social

work practice. The more seasoned and experienced participants appear to exhibit a higher level of professional confidence than their younger, less experienced counterparts. As Subject 11 stated, “I am able to cope because I respect and admire the resilience and coping abilities of my clients.”

Subject 3 revealed that it was not until his participation in this study that he acknowledged how much he had been affected by the high exposure to mortality and client death in his daily work. This was a true benefit of participating in this study.

Two of the subjects were dialysis social work supervisors who, aside from their administrative duties, provided direct care to dialysands and carried a regular full caseload the same as the social workers whom they supervised.

Professional respect was a recurring theme amongst the respondents. I found profound meaning at the beginning of my interview with Subject 4 when she asked me, “Am I being paid for this?” I thought I had made it clear that there was no financial reward for participation. I believe this was Subject 4’s way of exerting her professional sense of self and will to be respected.

Subject 6 shared his anger regarding the way dialysis social workers are treated and overworked. He identified himself as a former police officer, which I believe helped him to deal with the protection and safety issues he uncovered during his interview.

As Beder (1999) asserted, “psychosocial stresses are a fixed feature of the lives of dialysis patients” (p.17). The results of this qualitative study demonstrate that stress is also a fixed feature of dialysis social work practice. Future research is needed to evaluate if stress is a mirrored and shared experience between the dialysand and dialysis social worker on the unit.

### **Bias/Limitations**

Qualitative research provides a certain “depth” to research in terms of descriptive measurement (Rubin & Babbie, 2008). However, social scientists who utilize qualitative techniques have to be cautious of bias and judgment. The present study yielded and revealed emotional responses regarding the social workers’ experiences with their high-risk population of clients, which may have served as a bias in this study. Qualitative studies provide a naturalistic and generalized view of group behavior.

One of the limitations of the study was the hesitancy or reluctance of social workers to participate, based on a presumed “professional fear” of releasing and unveiling their thoughts regarding work-related stress. The participants may have opted to offer socially desirable answers similar to “gate-keeping” in order to protect their professional sense of self. The subjects may have possibly constructed a perception of professional fear of appearing weak and vulnerable. Socially desirable answers may impact the validity of the data (Ashby et al., 2005). To prevent this likely bias, I diligently answered any questions regarding subjects’ concerns; specifically regarding the impact of their participation in the study on their professional practice.

A second limitation of the study was the small subject size and lack of diversity of the subjects. Small “N” studies always have an issue with generalizability. Hispanic, Asian, and African-American social workers were hesitant to volunteer and asked many questions about how their participation would impact their current job status. I am now an advocate to encourage more social workers from diverse backgrounds to participate in future research regarding professional experiences. With assistance from the NASW, through professional education workshops and discussions, we could alleviate the fears

and hesitancy of social workers from different ethnic and cultural backgrounds to participate in professional research.

### **Implications for Future Practice and Conclusion**

It appears that there needs to be more grief counseling on a structured basis, not based on the symptoms of the social workers. Every death has meaning and should be responded to including institutionalized “mental health days.” A workshop regarding how to work with difficult patients as well as team-affirming activities may be beneficial to dialysis practice due to the high level of exposure to noncompliance leading to client death and mortality on the dialysis unit.

Subjects 2 and 7, who were two of the youngest and least experienced social workers in the study, requested implementation and development of courses at the MSW level to provide a greater understanding of how to navigate/access patient health insurance coverage. Such an educational module would insure that dialysis social workers are able to optimize the services received for clients through their insurance coverage. The two subjects, who are new graduates, suggested that MSW programs acknowledge insurance authorizations as an occupational skill, especially in the new age of technology where many of the authorizations may be requested online via computer. The use of more technology in social work practice may lead to new techniques in alleviating paper work.

In regards to service delivery, there is a need for future development of safeguards and programs to address patient denial in order to lower the rates of suicides caused by refusal of dialysis care. Future research may be needed to explore constructs of specific situational stressors such as the impact of Hurricane Sandy and budget cuts for dialysis

services and how these types of stressors impact dialysis social workers and their practice with a highly vulnerable and complicated client population.

## **APPENDICES**

### **Appendix A**

#### **Proposed Semi-Structured Interview Guide**

##### **Background Questions**

- 1) What is your educational background in the field of social work? BSW, Yes or No? MSW, Yes or No? Doctoral Degree, Yes or No?
- 2) How many total years have you been practicing social work?
- 3) Can you give a description of what it is like to work as a dialysis social worker?
  - a) Thinking of the last year or previous six months, what shift do you work?  
In your present position, what are the personal costs and health risks of the position, in regards to environmental concerns? 2) What are the liabilities?
  - b) Based on your experience, how is your work experience as a dialysis social worker different from your experience in other social work positions? How is the experience with stress different? Is your coping style different as well? Are the resources to help you cope different as well?
- 4) In what year did you begin your career as a dialysis social worker?
  - a) What are the main tasks?
  - b) What are the main challenges?
  - c) What are the main stressors of the position?

##### **Caseload**

- 1) How large is your caseload?
- 2) Can you tell me what it's like to work with your current caseload of patients?
- 3) In regards to socioeconomic issues, please describe the demographic range of your caseload.
- 4) How do you define patient acuity?
- 5) How do you define high acuity?
- 6) Can you give an example of a high acuity patient type?

### **Internal Coping**

- 1) What is the stress of your work? If so, please describe your experience?
- 2) When was the most stressful experience, what was it like?
- 3) What was the best day you've had at work as a dialysis social worker?
- 4) What was the worst day you've ever had as a dialysis social worker?
- 5) Let's go back to the most stressful event, who or what did you use to cope with the stress?
- 6) What was the most stressful aspect of managing this event? What was the least stressful aspect of managing this event?
- 7) How do you cope? What helps? At work? Outside of work? What techniques/activities do you use?

### **External Coping**

- 1) Do you find yourself ever missing days from work to cope with professional stress?
- 2) When was the last time you threatened to quit?

- 3) Who is the first person you go to when you have a stressful event?
- 4) Describe your level of support by your administrators/supervisors?
  - a) Can you give an example of when you felt your supervisor was supportive and when you thought they were not supportive during an event?
  - b) How often do you meet with other members of the interdisciplinary team to discuss and track the status/ progress of patients? Describe your level of support from this body?

### **Professional Organizational Support**

- 1) Do you belong to any professional organizations?
- 2) Are you a member of a union? NASW or local affiliate chapters? National Association of Nephrology Social Workers?
- 3) If so, what kind of support do you receive and how do you find it to be helpful?

### **Administering the KDQOL-36**

- 1) What is the KDQOL-36 Survey?
- 2) Do you administer the KDQOL-36 survey to your clients? If so, what is your experience with stress during this process? What aspects of the survey process do you find stressful, if any?
- 3) From very stressful to least stressful, how would you rank using the KDQOL?

### **Conclusion of the Interview Process**

- 1) This is the end of the interview, is there anything you would like to add or share at this time?
- 2) Please state your age and gender/identity, if comfortable.

3) Thank you for your participation.

## **Appendix B**

### **Consent Form for Qualitative Semi-Structured Interview**

Dissertation Project

Making the Connection: Using Social Constructivist Theory to  
Examine Dialysis Social Workers' Perceptions of Stress

#### **Introduction and Purpose of Study**

I am a graduate student in the DSW program at the University of Pennsylvania School of Social Policy and Practice, conducting semi-structured interviews and analysis to obtain data to complete my dissertation.

#### **What is involved?**

The primary researcher will conduct a total of twelve semi-structured interviews which will each take about an hour to an hour and a half. I will read and code your responses guided by Grounded Theory and Social Constructivist Theory.

I will not ask specific questions about patients, or their demographic/medical information. Your identity will remain anonymous. I will track your responses and protect your identity with use of a tracking number numbered from 1 to 12.

#### **Confidentiality**

The information you share will be kept strictly confidential. I will not share information about whether or not you participate in this project with anyone. I will never use your name, personal information or information about where you live or work in my write up of the interview.

Nothing with your name or other identifying information (names, quotes and places mentioned in the interview will be included in the final dissertation).

#### **Risks of Participating**

The risks of participating are minimal. The ways that confidentiality will be protected have already been described. In the unlikely event that you find that what your participation in this study is upsetting to you during or after you have completed the interview process, please be in touch with me. I can offer resources and/or referrals to assist you. I will provide you with some names and numbers of individuals or agencies that can provide further assistance. You are also able to view the final draft of this dissertation upon request.

#### **Benefits of Participating**

Although completing the survey will not help you directly, it is also possible that having that having a chance to express your perceptions will be an interesting and possibly even a rewarding experience for you.

#### **Compensation**

No monetary compensation or gifts will be provided for your participation.

If you have questions about the project after the interview is over, please feel free to contact me:

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**Your participation is completely voluntary.** You do not have to participate in this project. There will be no negative consequences if you decide not to participate or not. If you don't participate, it will not affect your job or anything else. You can also refuse to answer any questions that you don't want to answer.

- Please circle this sentence if you would allow the researcher to contact you for clarification or expansion of iterative themes of any of your responses. Please write in your phone number or e-mail, this will be used only if needed \_\_\_\_\_.

By verbally consenting to this consent form, I am indicating that I have had all of my questions about the interview process and this entire process answered to my satisfaction and that I have been given a copy of this consent form in-person. I will say "Yes, I willingly participate in this study"- I understand that my answer will be audiotaped to confirm my presence.

Subject's Assigned Study  
Identification Number:

\_\_\_\_\_

Date:

\_\_\_\_\_

Interviewer Signature:

\_\_\_\_\_

Interviewer Printed Name:

\_\_\_\_\_

Date:

## Appendix C

### Clinical DSW Dissertation Qualitative Interview Field Notes

#### Subject #1

Aug. 29th, 2013 5:48pm Philadelphia, PA Local Supermarket/Restaurant

MSW - Temple University. African American Female age 46

Practicing Social Work since 1991. Has had the same job since 1991 at Dialysis Center.

Feels a tremendous amount of support from co-worker and administration.

Admits that she walked around with a resignation letter when she was really fed up.

Workaholic?? Single no children, her whole life is her work.

#### Subject #2

August 31st, 2013 4:30pm Philadelphia Courtyard Marriott Bar 19

Youngest Participant-New Grad Caucasian female age 24.

MSW 1 year ago-Only been practicing since last October 2012 Fordham University: Had only one other position besides her current one as a dialysis social worker. Bachelor's in Psychology.

Discussed her role in referring patients for transplants.

Co-morbidities

-noncompliance

-depression

Others not seeing the importance of social work. Lack of respect for past experience.

Resistance /denial from both staff and patients.

Hard job-patients are more resistance.

More stressful-she has experience in mental health

New mentality-“Clients feel a sense of entitlement”, don’t wish to pay co-payments, want everything for free “I deserve that”. Patient demands. She works out of two different facility sites

Rural Site-patients are more independent, take more initiative, more family involvement. ESRD patients stop working in the rural areas, her overall experience with the rural area clients is less stressful. As opposed to the city site, it’s non-stop, last minute concerns, transportation issues, coddling. Actually are more patients in the rural site. In the rural area, the clients are working class, middle class, retired. City setting-more poverty, more resources in the city-more accessible to services. Most stressful event was a “302” a client suicide-a middle age female client fatality.

Supports:

Corporate Social Worker “trainer”-call him on his cell phone. Nurse manager is her supervisor. She tends to go to the dietician for support. She is the only social worker at both facilities.

Feels burned out at the end of the day. Works from 8:00am-4:30pm.

Best moment was when a client listened to her

Feels stressed when a client asks to see her other than a day they’re assigned.

Supports: Outside groups of friends, all of her friends are social workers. Turning to other SW.

Discussed most stressful event: internalized the death, very hard being a new MSW/SW, blamed herself, wished she could have saved the client. Has a day off once in a while.

To deal with this tragedy, she took many days off, she felt like resigning. The corporate social worker was very supportive (really good experience)

First person she relays on is the dietician at work, then corporate social worker, the rural site administrator is very supportive.

Discussed Strength based approach to dealing with stress.

Mapping her experience: One Social Worker, she works at two sites, she deals with two administrators, feeling dumped on by nursing staff.

Feels like an insurance agent, feels that MSW programs should address/give information on insurance(s).

Meets once a month with the dietician, social worker, nurse, attending physician, water supplier, discuss care plan of each client.

Once a year conducts KDQOL-36 only need to do it once a year, since experiencing the client death/suicide, she administers it every 3 months on each and every client to deter another suicide.

Action plan/coping

“How we can support clients after 90 days”

The KDQOL-36-hand it to the client or you can sit with them if the client wants, especially with older clients, print it out paper survey. She find it useful helpful. She likes administering it. Only stressful thing is that they don't bring it in. Dealing with insurance. \* Thinks insurance course should be taught in MSW program. Implication for practice. Discussed Medicare trying to cut 12% due to government cuts.

The least stressful part of the job-she like to help people, likes seeing clients.

Most stressful-Transportation-clients can be called in the middle of the night for a kidney transplant, how will they travel to the facility?

Staffing is stressful-personality clashes/conflicts

Maintaining level of professionalism.

Subject #3

September 2, 2013 10:05am Diner in Brooklyn, NY

Caucasian Male, age 54-MSW from Fordham University Practicing for 19 years-- 10 years practicing dialysis social work.

Helping with insurance entitlements—SSI/SSD-get into PA, Admissions/Intake, Chart makeup, review/accept patient, education component/teach patient about treatment options. Psych counseling-specific to what's going on while they are on dialysis chair.

Challenges-keeping up with many tasks administrative work.

Fair amount of work treatment plans. Patients surveys at least once a year for compiling patient data, the survey assessment tool used is mandated by Medicare.

Tackling all the tasks we have is a main/major stressor.

Risks of needle sticks has to be aware on the floor-tries not to be too physically close-- thus overly concerned about the lack of confidentiality, possible exposure to disease, Hepatitis patients-required to wear a gown on the floor, Hep B, TB/Slips/Falls, fear of slipping/falling/sharps.

His main concern \* confidentiality, open unit, chairs are 6-8 feet apart, not enough privacy, using movable chairs, tries to invite patients to his office, he has a nice office.

Their facility was flooded during Hurricane Sandy, Clients were moved to hospitals/nursing homes, had capacity to accept at other "sister sites" took 6 months to

return, Hurricane Sandy experience strained relationships with clients, he had to work later hours, clients were staying for later shifts, most returned back to the site after Sandy.

\*Transportation is a huge issue/barrier to care.

Dialysis Unit Practice-Open on the floor, on the unit, less time, less privacy.

10 minutes-doing constant rounds

Stress regarding referrals/administrative, multiple agencies/insurance reporting to

### IPRO Network

CMS Medicaid, monitor, tracks attrition rates, deaths, transfers, once a month.

1-2 people he reports clinical information, medical doctors, dietician, community person, network community outreach reporting-feels (branched out) Insurance bitter, multitasking, has adopted.

National-Regional Corporation Supervision/Leadership.

Divisional Supervision-NYC/Bronx/Yonkers

Lead Supervision-Brooklyn

-He has become used to it; small caseload now, less patients, 6 other social workers, 60 patients-3 days a week, more administrative workload during the week.

-Corporate Social Worker, National Social Worker, no social worker supervisor, there is a nurse manager.

-Divisional lead-meet quarterly meetings with the other six social workers, talk about social work issues.

80-90% on SSI/SSD lower income, retired/little income 1 or 2 who are rich-take car service

Immigration-mix-difference-socioeconomic

Asians, Indians, Pakistani, Middle Eastern 20% Hispanic, 25% African-American

Small percentage from Haiti/Various Caribbean

Russian 20%-30% Spanish Speaking, Russian staff on site

Have to use phone translation service.

Multi-tasking too much deadlines on top of deadlines; everything is due at the same time.

Urban patients are more savvy.

No challenges with patients but with administration.

Adaptation-coping; various sites=various administration=learning how policies work, learning their styles, what makes them upset.

### Coping

High amounts of dialysis stress, so many medical issues, many medical issues, cardiac disease. hypertension, more ill, not as healthy genetics.

Experienced a client suicide, depressed patient, patient was isolated/alone.

Dealing with higher levels of mortality, 1-2 clients die a month.

He has a background in HIV counseling.

Center has fun events, talking in the lunchroom, coping, accept high mortality rates.

Shares office with dietician, informal.

No formal support-lack of support, strong connections between dialysis SW and dieticians.

He has a good relationship with the clinical nurse.

Dietician and Nurse help him to cope. Spoke about his daughter in college.

A good day is when everyone is smiling.

Stressful experience is obtaining authorizations (insurance).

Not much absenteeism. Plan extra days off- “I say I quit to myself”.

Fairly good support-20% when support sucks, 80% good support. Supportive when he had a lot of things going on when supervisor is stressed and adding stress to the worker. Once a week “quality” meeting, administrative thing, informal meetings with staff/clinical nurse, MD’s often informal. 5-6 nephrologist, 1-2 are there every week. KDQOL-36 Give it to them offer brief description-score it-print out feedback, scoring it is stressful administrative side is stressful, he is behind, some refuse, they like doing it, has to be completed during the first 90 days of treatment. Spanish/creole version on client complained about the translation. If they don’t improve it Stressful. The feedback is to help improve client’s quality of life-it’s a great idea, Doesn’t find it stressful (a 2)—he has a lot to learn about scoring it.

Additional comment-felt the interview was helpful, gave him an overview of the field, made him think about things he was not aware of.

Subject #4 September 4, 2013 6:30pm Library  
Caucasian female-age 58

MSW Fordham University-12 years practicing, started working as a dialysis social worker 2 years ago.

Don’t have insurance, a lot of needs/few resources, tries not to worry but she does very little to offer them. Several patient deaths, experienced two deaths on same day, very difficult.

Resilience, immigrants/sacrifice-no experience with suicide per se, amputations due to diabetes. Time factor/privacy issues, a lot of paperwork, dealing with undocumented

clients, uninsured, relying on family members. Had 52 clients now has a caseload of 37 clients. She likes outpatient, not inpatient.

Selling/privatizing the unit. Decreasing patient census.

Less & less resources.

Client death is the worst experience-14 client deaths in 7 months

Best day –holiday time on the unit. Good team/staff, supportive co-workers, husband, daughter, lack of support from supervisor. No absenteeism-she was per diem now full time, has her own office.

She divides her week into patient days Tues/Thurs and days for paperwork Mon, Wed and Fridays.

Threatened to quit five times---co-worker and husband talked her out of it. Supervisor is an LCSW, staff helpful PA's.

Once a month do rounds; meet with patients as a team; once a month- do care plans. 6-7 patients a moth specific.

E-mail/call PA's/Nephrologist.

KDQOL-36-action plan finds it useful-doesn't find it stressful-stress in asking to do it and to have it returned.

Hard to divide personal life from health (subjective).

This subject sounded disappointed that there was no financial reward for participating in the study.

Subject #5 September 11, 2013 5:08pm Local Cafeteria  
African-American female-age 46 (Dialysis Social Work Supervisor) MSW-Hunter  
College-1998 BS History/Political Science/Spanish Mt. Saint Mary's College-Semi-  
Bilingual

Practicing SW since 1989

Became a dialysis Social Worker 5 years ago.

Educate on disease whether newly diagnosed—comorbidities-heart, DM, HTN, tasks, organs begin to fail. “Suddenly placed on dialysis”, supportive therapy, “life-saving therapy”.

Main challenges: lack of resources, federal constraints, funding, changes in medicare (cutting paying for Nepro supplement for patients with low albumin levels, now medicare is strict in order to get it. Patients have to buy it-it cost \$25.00. Physician has to write a reason/justification. Resources for daily survival are not there/not readily available.

\*“Working towards acceptance-disease not accepted, out of the blue onset” Functional “out of the blue”/new onset of End Stage. The new diagnosis is the hardest for patients to accept.

Surgery due to medication on dialysis, HTN, denial, kidney function to recover, they tell you there is nothing wrong with them.

Full blown-kidney failure-great challenge- if the patient can urinate, they often have hope to recover. Industry Myth-that kidney failure means you can't urinate.

Stressors: immediate gratification, intricacy of dialysis, if you are good at what you do, other issues such as homelessness, they have to stop working maintaining finances.

Effects on marriages, spouse has to be “bread winner”/financial support; risks never enter her mind; part of the job; what are precautions. There is a separate cubicle/ isolation room for Hepatitis B patients, we have to wear protective gear while providing services. We also experience patients who have mental illness-active or dormant.

\*\*\*Average risks of any other medical worker-part of her job---didn't mind sacrificing for patient.

Immuno-suppressed patients, liabilities. Basic core principles. Ethics/professionals, subjective liabilities. Evening patients are seen 5:30pm-6pm.

Stress is different in dialysis social work; some aspects are less stressful. Coping is by case by case-things overlap-children/families, people have basic needs. Workload is less than in say children's services.

Coping skills adapt to the situation—

Caseload

50% adults 50 % children working middle class

Ages 3-73 -- immigrant population

Stressors:

Paperwork, lack of organization, lack of familiarization of local/federal government

I PRO/CMS/DOH

Understanding that they are ill/understanding/identifying the issues of being on a machine, not nice patients, inappropriate client behavior-it's not about me as a worker.

Don't take it personal, purposely malicious patients, abusive patients, moving from unit to unit. Poor behavior has to be stopped at the gate. Lack of education (patients):

helping despite their challenges.

Death-mortality rate accepting patients' death easier when they are elderly. They admit they are tired "ready to go home".

Here on Monday gone Wednesday. Have complications after transplant, massive heart attacks/ coronary, children's deaths are always hard. "God took home an angel". Deaths are always hard. Never experienced a client suicide yet. Depression is a major issue in dialysis social work practice (SHOULD have probed more here).

"Know your people, know your patients, ask are you okay, being in tune with the client community.

Vice versa, patients are in tune. Patients are quick to identify you are changing/not doing well. It's a give and take, it's a family-"world of dialysis".

Most of days are good days. No matter how frustrating-there is always something good-positive, staying optimistic. "A successful kidney transplant makes the best day for me."

Never have a horrible day "Accomplishing one goal professional goal a day-reading notes completing work.

"Flipping out" (should have probed more here).

Support

Colleagues-whole clinic are colleagues-The whole team, what's best for the patient.

Family is a big source of support-aunt, father's sister's, her dad, lives with mother aunt, her dad, friends look out for each other.

God-always available-Giving God the Glory.

Having a form of outlet not social work related-enjoying private time-owns a Karaoke

Business does make-up, recreation, retail therapy, you would be in loud place if you didn't have an outlet.

Stressors:

Seeing someone three times a week, not seeing them anymore is stressful. Sad events are least stressful when you see it coming-----everyone from the clerk to the doctor-we all know it's happening.

Take mental health days-three deaths in a row-supportive administration-informally support each other-talk about it.

The staff members never shut me out, doctors are open.

Quit-have those thoughts every other day (especially when the three clients died), all in the same month-she attends client funerals, mourn in my own private way. 2012 was the "death year". So unexpected-came from left field-kind of expected "wrapping myself around it".

Coping-Watching cartoons all day-ate hot dogs-surfed the internet, took time for me, always has supportive supervisors/administrators, she has a high professional skill level, not stepping on toes.

Administration-Always supportive---articulate what the problem is-find a happy median.

Don't judge by appearance.

Documentation-give/take-we do what we need to work.

Once was asked to compromise integrity as a social worker-don't falsify.

Meeting with staff- "IT" means interdisciplinary team meeting-every three months; PI-performance improvement meetings once a month-social workers share statistics and review referrals from the community & hospital.

Insurance issues, transient patients, more than normal super patients (should have probed more). Sickly always in the ER, compliance lab work/affect dialysis care.

KDQOL-36

No stress—90 days to do the first survey, then conducted on an annual basis it is a bible, it is a tool-CMS is still looking at mandating it.

You know who is on your caseload. Patients can decline. Annual psychosocial-does not consider it stressful (level 3).

(Subject yawned during interview-I should have probed).

Lack of organization can be stressful

Caseload 75 patients to every one social worker.

Quarterly notes

SW not stressful-I have a system-two workers to supervise-1st and 2nd week of the month-notes are completed. I am free to supervise/review their work.

Subject #6 September 17th, 2013 5:55pm Flatbush Farm/Barn Bar Outside Garden

Caucasian male age 64-hearing impaired-the interview went over time to accommodate his disability. MSW Fordham University Practicing SW since 1980 -30 years of experience in social work-First introduced as an intern to dialysis social work. Has an MBA and a Certificate in Gerontology. Former police officer.

Pre-Interview Information-Talked about career changes-In & Out of Social Work-MBA.

Talked about being a bus driver-Feels like a police officer at his site-has to say “knock it off”.

“30 days notice” and then remove problem patients. Notify DOH, ESRD-IPRO network about the patient in writing.

Describes his site as having tough clientele-for example when they would cannulate one specific patient-if she felt pain-she would attack/ claw staff.

One of his colleagues had a breakdown on the unit 2 months ago. Observed fighting between clients/staff, Almost physical experience -- "Subject looks like Paul Newman". Conscious use of self with clients. Clients cursing at other patients-threatened clients with transfers. Client threats, encouraging staff to leave "don't subject yourself to client abuse.

Gave several examples of clients being threatened and abused by staff. He feels like a peacemaker "protector". Walking away when clients are angry, volatile, provocative, abusive-sometimes the clients bring attorneys, friends to initiate discussion arguments, internal investigations. Dealing with patients who are mentally ill/ paranoid, have behavior issues.

Managers of units have to be stern "trust" is an issue. Establishing trust with clients. Harsh words are like hand grenades. "I'm going to make a complaint" you're not professional, I'm reporting you.

Probe-Had two jobs-many of my participants have multiple jobs in dialysis 2-3 positions. Very common for social workers to float to other sites.

Corporation rules governing patients.

Social Work Personnel ratios-sometimes fulltime SW-there is 1 SW to 145 patients.

They (the corporation) don't understand what's going on.

Main tasks:

SSI, benefits, Insurances, legal issues, immigration, emergency Medicaid. Most of the medication is not covered.

## Liabilities/Risks

Risks of being assaulted/violence.

Being exposed to certain pathogens/illness, Hepatitis B., illness, he contracted pneumonia 4 times, was out of work for a month.

Coping style is the same. Don't look at the pathology-look at the person. (Observation-Subject has a strong Brooklyn accent).

More independence in other fields.

Since there are no home visits you miss seeing clients in their own environment and bonding in time.

Always interrupted by other individuals. You feels always in the way of their dialysis process.

Client wants a letter for traffic court. "I'm on dialysis"-speaks to sense of entitlement.

Very stressful-patients use their dialysis as a weapon, if they don't get it their way, they complain.

Very stressful dealing with clients who complain.

Sequestration with dialysis-there will be a 12.4% cut in the federal dialysis budget next year. Commercial insurance is the gold mine. The government (Vets, Medicaid) are a loss. There will be very strict reimbursements, referred to as 'bundling' to cover treatments and medications on units.

Federal Government via Medicare will only provide payment for-Epogen-very expensive—The state Medicaid program will intervene to help cover costs for patients.

In regards to supervision, There is a Lead SW for the state for my company, they are not supervisors, they are intermediaries-the idea started on the west coast. Social Work intensive initiate-transition many functions off of social workers such as transportation-Crown Web statistics, medication.

Talked about going to college during the Vietnam War/Recession, how that experience shaped his career, he attended a Catholic university-spoke about the experience of being taught by Dominican nuns affected his life/shaped world view, especially during the war.

Stress-Client transfers working with shelter patients, transportation issues.

Talked about his current/second marriage. Sounds like his career/dedication/long office hours- affected his first marriage.

What else can you do? You have no choice but to cope. His best friend died recently and he was on dialysis. Professionals try not to take it home. The politics of the job made him want to quit once.

States that he was blamed for something while he was on vacation. Felt like he was going to have a breakdown. He actually attended counseling with an LCSW between 1980-1983.

Therapist encouraged him to leave his job. Therapist warned that he was on the edge of a breakdown. He resigned felt better \*\*I think he shed a tear” Still went to work despite stress-had to pay bills mortgage-\* He covered the microphone of the recording device so he could talk about his mother/childhood. Freudian issues with his mother-beyond redemption people-had a rough child. Maybe this give him the ability to connect with clients.

Cathartic experience of ex-father in law's death. Asked for a divorce on his birthday.

"Over dedication" to his career may have affected marriage-he doesn't feel so.

KDQOL-36 not difficult to administer-based on the University of Arizona study-1500

dialysis patient measures quality of life/coping with dialysis in relation to other patients-

enter the responses into the program-score & patient summary-CIA Comprehensive

Integrated Assessment-30 days Initial doctor, nurses, social work, dietician. Plan of care-

17 pages and 13 pages a lot of paper work, another one after 90 days.

Couple of experiences with dialysis SW suicide, elderly man/very supportive family,

passive suicide, discontinuing treatment, after a few weeks he died. He supported hem in

termination of dialysis.

He's had various occupations in the past EMT/Police Officer/has a MBA-

businessman.

Distorted body image.

Loss of independence.

Trained to do vs. what you are actually doing.

Maslow's Hierarchy of need, no privacy to interact, noise on unit, nurses/staff, running

around, constant interruptions, televisions at unit.

Helping patient's cope with insomnia/ poor sleeping habits, transportation issues, dry

skin. Participating in Webinars, many internal emails.

Look on the machine & tell how much time is left (timer on machine).

Client excessively scratching their bodies due to illness-client mortality "God was kind".

Slow progression to death.

Progression to walking, cane, walker, wheel chair, stretcher, death.

Not enough time to administer KDQOL-36. Time consuming. Something that has to be done.

Too many patients to survey/interview at one time.

Sometimes they have the same start date in regards to evaluations being due. Exclusions (dementia- refusals to complete it) they never return it. Previous history taking it. Not enough time. This subject states that he will soon retire in a year and a half.

Interview ended at 8:30pm total time 3hours.

Subject #7 October 1, 2013 12:00pm Philadelphia PHC  
Caucasian Female age 32 MSW Widener University 2008 Practicing Social Work for five years, has been practicing dialysis social work for 1 year.

Stressors:

Insurance barriers, feels like an insurance broker, transportation.

Feels like she is doing mathematical equations.

Transportation is a huge barrier, a lot of what we do-feels like a transportation coordinator.

Rewarding-good client contact, many creative ways to work with clients, general counseling, this job makes you more conscious of your own health.

Dealing with the same issue twice a week can be frustrating. Too much going on. High level of need, fixed income, other issues, before challenges dialysis. Federal mandate certain # hours per client.

Support:

Dietician serves as her as main support, clinical case manager. Outlets are reality TV to relive physical anxiety.

Older clients make it easier to cope with death.

Stressors—"Codes" on the unit seeing it live on the unit. A "lived experience" for the entire staff. Protective factor. Being aware. Family members are not ready to deal with death.

Yes she has wanted to quit. Supportive Supervisor, great interdisciplinary team.

KDQOL-36-another thing to be done. Low level of stress.

Deal with the most important tasks/things first.

Subject #8 October 3, 2013 11am Staten Island –  
60 year old Caucasian female

MSW University of Connecticut 1971 42 years in SW Started working as a dialysis social worker in 1978.

"Something happened last week which made them.

5.5 years at this current site. The air conditioner was very loud at this venue.

Meeting mandates-directed/misdirecting towards patient care incredible mandates within dialysis-feels pulled in many directions. Rather be out doing patient care. Putting out "fires" hard to balance the rest of your work. Follow protocols, overworked. You ask yourself, are you contributing to the patient's overall quality of life?

Regulations have increased over the years. Frustration increased.

Caseload:

160 patients, 8 in home dialysis 4 peritoneal Dialysis.

1 full time SW and 1 part-time SW.

Large middle class, retired from city employees, upper class clientele.

Handful of patients-Asian, Italian, Hispanic.

Watching people decline, decompensate, family members supporting declining, patient right to refuse services.

Never threatened to quit, will stay late, not missing days to work. She has a lot of support, (She looks like a photo of Ruth Smalley-pioneer in Social Work Practice.)

Subject #9 October 3, 2013 11:50am Staten Island  
49 year old Caucasian female

MSW Audrey Cohen College Practicing for 18 years started dialysis social work practice from school internship. (Dialysis SW sinks its teeth into you) The experience followed her always to work in this field) Not like cancer, chronic terminal) not difficult to empower.

Motivational counseling-sense of loss, inpatients mourning past lives no longer can perform tasks. She feels like a parent at times.

“How do you quantify what you do?” this work-dialysis social work.

Gender issues-male patients feel an extreme sense of loss in regards to inability to work and impotence.

No

Every other day

Weekly meetings with interdisciplinary team once a week. Ongoing during the week.

Subject #10 October 9, 2008 Local cafeteria Brooklyn, NY  
Caucasian male 42 MSW Fordham University 1999 Practicing Social Work for the past 17 years. Dialysis Social Work practice since 2008.

Adjust to new life on dialysis-patient's don't have an idea-adjusting to rigors. Applying for benefits-work adjustment—complying with everything.

Professional challenges-distancing oneself—audited.

Subject #11 Brooklyn, NY October 11, 2013 1pm  
52 year old Caucasian female Columbia University MSW 1982

Worked in Preventive Services in the past Dialysis Social Worker for the past 9 years.

Didn't want to write to make her nervous

Subject #12 Bronx, NY October 17, 2013 11:00am  
African American –Female age 37 Pregnant Fordham University-MSW ( years practicing as dialysis social worker-main job out of grad school.

Acclimate new patients, transitioning patients, helping clients cope.

Insurance

Working with various personalities

Setting boundaries.

Other jobs were more clinical. Miss “One on One” time, misses escorting clients to appointments.

Implementing stressful at times try her best to get it done.

Cope-Walking Yoga, talking to manager

Challenging good bunch of patients.

“pounce on current client needs”.

Insurance stays active, working class retired, older population. First week at work, someone coded on the machine after interviewing her. Had to call her family/cried.

Support/Coping

Called her mother-personal faith, yoga, meditation, her mentor helped her.

She is off every Friday-has time to recoup.

One time threatened to quit at another facility.

In regards to the KDQOL 36-rates it as a “4” in difficulty administering.

## REFERENCES

- Aboa-Eboule, C., Brisson, C., Maunsell, E., Masse, Benoit, Bourbonnais, R., Vezina, M., Milot, A., Theroux, P., Dagenais, G. R. (2007). Job strain and risk of acute recurrent coronary heart disease events. *Journal of the American Medical Association*, 298(14). 1652-1660.
- Albrecht, K. (1979). *Stress and the manager*. Englewood Cliffs: Prentice-Hall.
- Al-Khalili, F., Wamala, S.P., Svane, B. Orth-Gomer, K. Schenk-Gustafsson, K. Prognostic value of exercise testing in women after acute coronary syndromes: The Stockholm Female Coronary Risk Study. *American Journal of Cardiology*, 86. 21-213.
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders*. Fourth Edition. Text Revision.
- Applebaum, S.H. (1980). Managerial/organizational stress: identification of factors and symptoms, *Health Care Manager*. Rev. 5(12).
- Argentero, P., Dell’Olivo, B. Ferretti, M.S. (2008). Staff burnout and patient satisfaction with the quality of dialysis care. *American Journal of Kidney Disease*, 51 (1), 80-92.
- Arikan, F., Koksall, C.D. & Gokce C. (2007). Work-related stress, burnout and job satisfaction of dialysis nurses in association with perceived relations with professional contacts. *Dialysis & Transplantation*, 36 (4), 182-191.
- Assmann J. (2008). “Communicative and cultural memory,” in *Cultural Memory Studies: An International and Interdisciplinary Handbook*, eds Erll A., Nünning A., editors. (Berlin: de Gruyter; ), 109–118.

- Auslander, G.K., Frank, A., & Weissgarten, J. (2004). Quality of life of patients with end stage renal disease at various stages of the illness. *Social Work in Healthcare*. 38 (2).
- Babbie, E.R., Rubin, A. (2008). *Research Methods for Social Work*. Sixth Edition. Thomson/Brooks/Cole:Belmont.
- Baker, A.J., Charvat, B.J. (2008). *Research methods in child welfare*. Columbia University Press: New York.
- Batson, H., Schwartz, M. (1999). Techniques to improve compliance in hemo-and peritoneal dialysis patients. *Nephrology News & Issues*, 54-58.
- Beck, A.T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4, 561-571.
- Beder, J. (1999). Evaluation research on the effectiveness of social work intervention on dialysis patients: The first three months. *Social Work in Health Care*, 30, 15-30.
- Beder, J. (2008). Evaluation Research on Social Work Interventions: A Study on the Impact of Social Worker Staffing. *Social Work in Health Care*. 47 (1).
- Bell, H. (2003). Strengths and secondary trauma in family violence work. *Social Work*, 48, 513-522.
- Berceli, D., Napoli, M. (2006). A proposal for a mindfulness-based trauma prevention program for social work professionals. *Complementary Health Practice Review*, 11 (153).
- Bergeron, L. R. (2002). Family preservation: An unidentified approach in elder abuse protection. *Families in Society: The Journal of Contemporary Human Services*, 83, 547-556.

- Berkman, B. & Weissman, L.A. Applied social work research. In Ed. Miller, R.S. & Rehr, H. (1983). *Social Work Issues in Health Care*. Prentice-Hall: Englewood Cliffs, NJ.
- Berzoff, J., Flanagan, L.M., Hertz, P. (Eds.) (2008). *Inside Out and Outside In*. Second Edition. Psychodynamic Clinical Theory and Psychopathology in Contemporary Multicultural Contexts. Jason Aronson: Plymouth.
- Birks, M., Chapman, Y., & Francis, K. (2008). Memoing in qualitative research: probing data and processes. *Journal of Research in Nursing*, 13 (68).
- Bishop, M.M., Rodrigue, J.R., Wingard, J.R. (2002). Mismanaging the gift of life: noncompliance in the context of adult stem cell transplantation. *Bone Marrow Transplantation*, 29, 875-880.
- Bleyer, A., et. al (1999). An international study of patient compliance with hemodialysis. *Journal of the American Medical Association*, 281, 1211-1213.
- Bogatz, S., Colasanto R., Sweeney, L. (2005). Defining the impact of high patient/staff ratios on dialysis social workers. *Nephrology News & Issues* 19 (2), 55-60.
- Böhmert M., Kuhnert S., Nienhaus A. (2011). Psychological stress and strain in dialysis staff-a systematic review. *Journal of Renal Care*, 37(4), 178–189.
- Borden, W. (2000). The relational paradigm in contemporary psychoanalysis: Toward a psychodynamically informed social work. *Social Service Review*, (September), 352-379.
- Boscarino, J. A., Adams, R. E., & Figley, C. R. (2005). A Prospective Cohort Study of the Effectiveness of Employer-Sponsored Crisis Interventions after a Major Disaster. *International Journal of Emergency Mental Health*, 7(1), 9–22.

- Bourassa, D.B. (2009). Compassion fatigue and the adult protective services social worker. *Journal of Gerontological Social Work*, 52 (3), 215-229.
- Boyer, C.B., Friend, R., Chlouverakis, G. & Kloyanices, G. (1990). Social Support and demographic factors influencing compliance of hemodialysis patients. *Journal of Applied Social Psychology*, 20, 1902-1918.
- Brescia S.B., Cimino, J.E., Appel, K., Hurwich, B.J. (1966). Chronic hemodialysis using venipuncture and a surgically created arteriovenous fistula. *New England Journal of Medicine*, (275), 1089.
- Bride, B.E., Robinson, M.M., Yegidis, B., & Figley, C.R. (2004). Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice*. (14) 27-35.
- Bride, B.E., Radey, M., Figley, C.R. (2007). Measuring compassion fatigue. *Journal of Clinical Social Work*, (35) 155-163.
- Brokalaki, H., Matziou, V., Thanou J. et al. (2001). Job related stress among nursing personnel in Greek dialysis units EDTNA ERCA Journal. 27 (4), 181-186.
- Brown, M.J., Chambers, J.C., Zhang, W., Lord, G.M., van der Harst, P., Lawlor, D.A., Sehmi, J.S., Gale, D. P., Wass, M.N., Ahmadi, K.R., Bakker, S.J.L., Beckmann, J., Bilo, H.J.G., Bochud, M., Caulifield, M.J., Connell, J.M.C., Cook, H.T., Cotlarciuc, I., Smith, G.D., de Silva, R., Deng, G., Devusyt, O., Dikkeschei, L.D., Dimkovic, N., Dockrell, M. (2010). Genetic loci influencing kidney function and chronic kidney disease. *Nature Genetics*. 42, 373-375.
- Brownbridge, G., & Felding, D.M. (1994). Psychological adjustment and adherence to dialysis treatment regimens. *Pediatric Nephrology*, 8, 744-749.

- Browne, T. (2006). Literature review: Nephrology social work: History in the making. *The Journal of Nephrology Social Work, 25*, 11-29.
- Burcher, P. (2012). The noncompliant patient: A Kantian and Levinisian Response. *Journal of Medicine Philosophy, 37* (1) p.74-89.
- Butler, A.H., Astbury, G. (2008). The use of defense mechanisms as precursors to coming out in Post-Apartheid South Africa; A Gay and Lesbian Youth Perspective. *Journal of Homosexuality, 55*(2), 223-244.
- Callahan, M.B. (1998). The role of the nephrology social worker in optimizing treatment outcomes for end- stage renal disease patients. *Dialysis and Transplantation, 27*, 630-637.
- Caron, C., Corcoran, K.J., Simcoe, F. (1983). Intrapersonal correlates of burnout. *The Clinical Supervisor, 1* (4), 53-62.
- Center for Workforce Studies, NASW. (2006). Licensed Social Workers in the U.S., 2004. Retrieved June 22, 2006, from <http://workforce.socialworkers.org/studies/intro.pdf>.
- Chaiklin, H. (1976). Needed: a generic definition of social work practice. Paper presented at the National Conference on Social Welfare, Washington, DC. Ed. Matthew Henk. (1989). *Social Work in Primary Care*. Sage Publications: Newbury Park, CA.
- Chan, R., Brooks, R., Erlich, J., Chow, J., & Suranyi, M. (2008). The effects of kidney-disease-related loss on long-term dialysis patients' depression and quality of life: positive affect as a mediator. *Clinical Journal of the American Society of Nephrology, (4)* 160-167.

- Charmaz, K. (2006). *Constructing Grounded Theory. A Practical Guide Through Qualitative Analysis*. Sage: London.
- Chater, K. (1999). Risk and representation: older people and noncompliance. *Nursing Inquiry*, (6) 132-138.
- Christensen, A. & Ehlers, S. (2002). Psychological factors in end stage renal disease: An emerging context for behavioral medicine research. *Journal of Consulting and Clinical Psychology*, 70 (3), 712-724.
- Christensen, A.J., Wiebe, J.S., Smith, T.W., & Turner, C.W. (1994). Predictors of survival among hemodialysis patients: Effect of perceived family support. *Health Psychology*, 13, 521-525.
- Clark, A. (1987). *Loving someone gay*. Millbrae, CA: Celestial Arts.
- Clark, C.C. (1980) Burnout: assessment and intervention. *Journal of Nursing Administration X* (9):39-43. In McConnell, E.A. (1982). *Burnout in the Nursing Profession: Coping Strategies, Causes, and Costs*. The C. V. Mosby Company: St. Louis.
- Coady, C.A., Kent, V.D., & Davis, P.W. (1990). Burnout among social workers working with patients with cystic fibrosis. *Health and Social Work*, 15 (2), 116-124.
- Code of Federal Regulations Website (Regulations.gov) 2013
- Cohen, M., Gagin, R. (2005). Can skill-development training alleviate burnout in hospital social workers? *Social Work in Health Care*, 40 (4), 83-97.
- Colligan, T.W., Higgins, E.M. (2006). Workplace stress. *Journal of Workplace Behavioral Health*, 21 (2) 89-97.

- Collins, S. (2007). Social workers, resilience, positive emotions and optimism. *Practice-Social Work in Action, 19*(4).
- Corey, G. (1988). Issues and ethics in the helping professions. Pacific Grove, 3<sup>rd</sup> ed. CA: Brooks/Cole Pub. Co.
- Council of Nephrology Social Workers. (2002). National Kidney Foundation. *Professional advocacy for the nephrology social worker*. New York: NKF.
- Council on Social Work Education. (1982). Curriculum policy for the master's degree and baccalaureate degree programs in social work education. New York: CSWE.
- Courtois, C.A. (2002). Education in trauma practice: Traumatic stress studies, the need for curricula inclusion. *Journal of Trauma Practice, 1* (1), 33-57
- Cowan, B.R., Young, A. A., Wang., V.Y., Nash., M.P. (2013). Investigating heart failure mechanics using personalized human biophysical models. *Journal of Cardiovascular Magnetic Resonance, 15*, E32.
- Cox, T., Griffiths, A.J. & Rial-Gonzalez, E. (2000). *Research on Work-Related Stress*. Report to the European Agency for Safety and Health at Work. Luxembourg: Office for Official Publications of the European Communities, Luxembourg.
- Coyle, D., Edwards, D., Hannigan, B., Fothergill, A. and Burnard, P. (2005). A systematic review of stress among mental health social workers. *International Social Work, 48*(2), 2001–211.
- Creamer, T. L., & Liddle, B. J. (2005). Secondary traumatic stress among disaster mental health workers responding to the September 11 attacks. *Journal of traumatic stress, 18*(1), 89-96.

- Crawford, K. (1996). Vygotskian approaches in human development in the information era. *Educational Studies in Mathematics*, 31 (1-2), 43-62.
- Cropanzano, R., Rupp, D.E., & Byrne, Z.S. (2003). The relationship of emotional exhaustion to work attitudes, job performance, and organizational citizenship behaviors. *Journal of Applied Psychology*, 88(1), 160-169.
- Cryer, B., McCraty, R., and Childre, D. (2003). Pull the plug on stress. *Harvard Business Review*, 81 (7), 102-7, 1818.
- Curtin, R.B., Svarstad, B.L., Keller, T.H. (1999). Hemodialysis patients' noncompliance with oral medications. *American Nephrology Nurses Association*, 26(3), 307-316.
- Cukor, D., Rosenthal, D.S., Jindal, R.M., Brown, C.D., & Kimmel, P.L. (2009). Depression is an important contributor to low medication adherence in hemodialyzed patients and transplant recipients. *Kidney International*, 75. 1223-1229.
- Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Worker*, 48, 451-459.
- Cyphers, G. (2005). Report from the 2004 child welfare workforce survey: State agency findings. Washington, DC: American Public Human Services Association.
- Czaczkas, J.W., Nour, A. (1978). *Chronic Hemodialysis as a Way of Life*. Brunner/Mazel: New York.
- Daly, J.M., Jogerst, G.J., Haigh, K.M., Leeney, J.L., & Dawson, J.D. (2005). APS workers job requirements associated with elder abuse rates. *Social Work in Health Care*, 40 (3), 89-102.
- Dane, B. (2000). Child welfare workers: An innovative approach for interacting with

secondary trauma. *Journal of Social Work Education*, 36 (1), 27-38.

Dane, B. Chachkes, E. (2001). The cost of caring for patients with an illness. *Social Work in Health Care*, 33 (2), 31-51.

Davis, P.G. (1997). Satisfaction with health care: A predictor of hemodialysis patient compliance (Doctoral Dissertation, The Louisiana State University and Agricultural and Mechanical College, 1997). *Dissertation Abstracts International: Section B: The Sciences & Engineering*, 57 (9-B), 5913.

Dermody, K. & Bennet, P.N. (2008). Nurse stress in hospital and satellite haemodialysis units. *Journal of Renal Care*, 34 (1), 28-32.

Devereaux, P.J. (2002) Comparison between private for-profit and private not-for-profit hemodialysis centers, a systematic review and meta-analysis, *Journal of the American Medical Association*, 288, 2449-2452.

De Wardener, H.E. (1973). *The Kidney: An Outline of Norm*. Fourth Edition. Churchill Livingstone: Edinburgh.

*Dictionary.com's 21st Century Lexicon*. Retrieved May 20, 2013, from Dictionary.com website: [http://dictionary.reference.com/browse/social\\_construct](http://dictionary.reference.com/browse/social_construct)

Dobrof, J., Dolinko, A., Lichtiger, E., Uribarri, J., & Epstein, I. (2001). Dialysis patient characteristics and outcomes: The complexity of social work practice with the end stage renal disease population. *Social Work in Health Care*. 33 (3/4), 105-128.

Donovan, J.L., Blake, D.R. & Fleming W.G. (1989). *The patient is not a blank sheet: lay beliefs and their relevance to patient education*. B.J. Rheum. 28, 58-61.

- Dorland's Illustrated Medical Dictionary. (1994). 28<sup>th</sup> Edition. W.B. Saunders Company/Harcourt Brace & Company: Philadelphia.
- DeOreo, P.B. (1997). Hemodialysis patient-assessed functional health status predicts continued survival, hospitalization, and dialysis-attendance compliance. *American Journal of Kidney Diseases*, 30(2), 204-212.
- Department of Health and Human Services Centers for Medicare & Medicaid Services 42 CFR Parts 405, 482, 488, and 498, Medicare Program; Hospital Conditions of Participation; Requirements for Approval and Re-Approval of Transplant Centers To Perform Organ Transplants (Federal Register/Vol. 72, No.61, March 30, 2007).
- Diakakis, M., Deligiannakis, G., Katsetsiadou, K., & Lekkas, E. (2015). Hurricane Sandy mortality in the Caribbean and continental North America. *Disaster Prevention and Management*, 24(1), 132-148.
- Edelman, I.S., Herman, T.S., Fimognari, G.M. (1968). Studies on renal aldosterone-binding proteins. *The Journal of Biological Chemistry*, 243, 3849-3856.
- Eisenbud, D.E. (1996). *The Handbook of Dialysis Access*. Anadem: Columbus.
- Eisenstein, E.L., Sun, J.L., Anstrom, K.J., Stafford, J.A., Szczech, L.A., Muhlbaier, L.H., Mark, D.B. (2009). Do income level and race influence survival in patients receiving hemodialysis? *The American Journal of Medicine*, 122, 170-180.
- Ellett, A. J. (2009) Intentions to remain employed in child welfare: The role of human caring, self-efficacy beliefs, and professional organizational culture, *Children and Youth Services Review*, 31(1), 78-88.

- Ellis, J., Ellett, A.J., & DeWeaver, K. (2007). Human caring in the social work context: Continued development and validation of a complex measure. *Research on Social Work Practice, 17*(1) (2007), 66-76.
- Elloy, D.F., Terpening, W., Kohls, J. (2001). Causal model of burnout among self-managed work team members. *Journal of Psychology, 135*, 321-334.
- Engel, R.J., Schutt, R.K. (2009). *The Practice of Research In Social Work. Second Edition.* Sage Publications: Thousand Oaks, CA.
- Epstein, L. (1989). The therapeutic function of hate in the countertransference. *Contemporary Psychoanalysis, 13*, 442-461.
- Ewing, R. and Manuel, J. (2005). Retaining quality early career teachers in the profession: New teacher narrative. *Change: Transformation in Education, 8*(1), 1-16.
- Figley, C.R. (Ed.) (2002). *Treating compassion fatigue.* New York: Brunner/Routledge.
- Figley, C.R. (2002a). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology, 58*, 1433-1441.
- Figley, C.R., & Roop, R. (2006). *Compassion fatigue in the animal care community.* Washington, D.C: Humane Society Press.
- Fine, R.N., Nissenson, A.R. (1993). *Dialysis Therapy. Second Edition.* Hanley & Belfus: Philadelphia.
- Fonagy, P. & Target, M. (2003). *Psychoanalytic theories: Perspectives from developmental psychopathology* (The interpersonal-relational approach: From Sullivan to Mitchell, pp. 204-229). New York: Routledge.

- Fortner-Frazier, C.L. (1981). *Social work and dialysis: The medical and psychosocial aspects of kidney disease*. Los Angeles, CA: University of California Press.
- Fothergill, A., Edwards, D., & Burnard, P. (2004). Stress, burnout, coping, and stress management in psychiatrists: findings from a systematic review. *International Journal of Social Psychiatry*, 50, 54-65.
- Friedman, E.A. (2001). Must we treat noncompliant ESRD patients? *Seminars in Dialysis*, 14(1), 23-27.
- Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American psychologist*, 40(3), 266.
- Glaser, B.G. (1978). Theoretical sensitivity. Mill Valley, CA: The Sociology Press. In Charmaz, K. (2006). *Constructing Grounded Theory. A Practical Guide Through Qualitative Analysis*. Sage: London.
- Glaser, B.G., & Strauss, A.L. (1967). The discovery of grounded theory. Chicago: Aldine. In Charmaz, K. (2006). *Constructing Grounded Theory. A Practical Guide Through Qualitative Analysis*. Sage: London.
- Gokal, R. (2002). Health-related quality of life in end stage renal failure. *Greek Nephrology*, 14: 170-3.
- Gokcakan, Z. (1991). The effectiveness of psychological counselling for long-term haemodialysis patients. *Dialysis Transplantation*. 20: 26-9.
- Golubic, R., Milosevic, M., Knezevic, B., & Mustajbegovic, J. (2009). Work-related stress, education and work ability among hospital nurses. *Journal of Advanced Nursing*, 65 (10), 2056-2066.

- Gonsalves-Ebrahim, L. Sterin, G., Gullledge, A.D. (1987). Noncompliance in younger adults on hemodialysis. *Psychosomatics: Journal of Consultation Liaison Psychiatry*, 28 (1), 34-41.
- Grassi, L., & Magnani, K. (2000). Psychiatric morbidity and burnout in the medical profession: an Italian study of general practitioners and hospital physicians. *Psychotherapy and psychosomatics*, 69(6), 329-334.
- Grau-Alberola, E., Gil-Monte, P.R., Garcia-Juesas, J.A., Figueiredo-Ferraz, H. (2010). Incidence of burnout in Spanish nursing professionals: A longitudinal study. *International Journal of Nursing Studies*. 47, 1013-1020.
- Gregorian, C. (2005). A career in hospital social work; do you have what it takes? *Social Work in Health Care*. 40 (3), 1-14.
- Gross, R., Mcilveen, R., Coolican, H., Clamp, A., & Russell, J. (2000). Psychology: A new introduction for a level (2<sup>nd</sup> Ed.). London:Hodder & Stoughton.
- Hackett, S., Kuronen, M., Matthies, A. L., & Kresal, B. (2003). The motivation, professional development and identity of social work students in four European countries. *European Journal of Social Work*. 6 (2) 163-178.
- Hamachek, D. (1992). Encounters with the self (4<sup>th</sup> Ed.). Javanovich College Publishers, Harcourt Brace.
- Hadley, M. (2008). Relational Theory. *Inside Out, Outside In, In Between, and All Around*. In Berzoff, J., Flanagan, L.M., Hertz, P. (Eds.) (2008). *Inside Out and Outside In*. Second Edition. Psychodynamic Clinical Theory and Psychopathology in Contemporary Multicultural Contexts. Jason Aronson: Plymouth.

- Haroun, L. (2011). *Career Development for Health Professionals: Success in School & On the Job*. Third Edition. SunRiver: Oregon.
- Henk, M.L. (1989) *Social Work in Primary Care*. Sage Publications: Newbury Park, CA.
- Hobfoll, S.E. (1998). *Stress, culture, and community: The psychology and physiology of stress*. New York: Plenum Press.
- Husserl, E. (1982). Ideas pertaining to a pure phenomenology and to a phenomenological philosophy. 1st book: General introduction to a pure phenomenology, trans. by F. Kersten. The Hague: Nijhoff.
- Hutchinson, T.A. (2005). Transitions in the lives of patients with end stage renal disease: A cause of suffering and an opportunity for healing. *Palliative Medicine*, 19 (4), 270-277.
- Hyman, O. (2004). Perceived social support and secondary traumatic stress symptoms in emergency responders. *Journal of Traumatic Stress*, 17, 149-156.
- Iliffe, G., & Steed, L. (2000). Exploring counselor's experience of working with perpetrators and survivors on domestic violence. *Journal of Interpersonal Violence*, 15, 393-412.
- Ifudu, P., Paul, H., & Friedman, E. (1998). Predictive value of functional status on mortality in patients on maintenance dialysis. *American Journal of Nephrology*. 18(2), 109-116.
- Inbar, J., & Ganor, M. (2003). Trauma and compassion fatigue: Helping the helpers. *Journal of Jewish Communal Service*, 79 (2-3), 109-111.

- Jackson, D., & Sullivan, R. (1994). Developmental implications of homophobia for lesbian and gay adolescents: issues in policy and practice. *Journal of Gay and Lesbian Social Services, 1* (3/4), 93-109.
- Jennette, C., Derebail, V., Baldwin, J., Cameron, S., (2009). Renal replacement therapy therapy and barriers to choice: using a mixed methods approach to explore the patient's perspective. *Journal of Nephrology Social Work, 32*.
- Jones, C. (2014) Stress and coping strategies in renal staff. *Nursing Times, 110* (10), 22-25.
- Jones, F., Fletcher, B.C. & Ibberson, K. (1991). Stressors and strains amongst social workers: Demands, supports, constraints, and psychological health. *British Journal of Social Work, 21*, 443-469.
- Johnstone, S. (2005). Wellness programming: Nephrology social work expands its role in renal disease management. *Nephrology News & Issues, 19* (12), 59-71.
- Kadushin, A. (2002). *Supervision in Social Work* (3<sup>rd</sup> Ed.). New York: Columbia University Press.
- Kalantar-Zadeh, K., Shah, A., Duong, U., Hechter, R. C., Dukkipati, R., & Kovesdy, C. P. (2010). Kidney Bone Disease and Mortality in CKD: Revisiting the Role of Vitamin D, Alkaline Phosphatase and Minerals. *Kidney International Supplement, (117)*, S10–S21.
- Kennedy, S.H., Craven, J.L., Rodin, G.M. (1989). Major depression in renal dialysis patients: an open trial of antidepressant therapy. *Journal of Clinical Psychiatry, 50*, (20/8).

- Khan, K.H. (2003). Chapter 8: Psychological Interaction and Its Therapeutic Impact on Patients' Physical and Mental Health: Implications for Health Care Providers. In *Allied Health: Practice Issues and Trends In the New Millennium*. Editors Lecca, P.J., Valentine, P.A., Lyons, K.J. 137-151.
- Kinzel, A., & Nanson, J. (2000). Education and debriefing: Strategies for preventing crises in crisis-line volunteers. *Crisis*, 21, 126-134.
- Kitchen, A. & Brooks, J. (2005). Social work at the heart of the medical team. *Social Work in Health Care*, 40 (4), 1-18.
- Kim, H. & Lee, S.Y. (2009). Supervisory communication, burnout, and turnover intention among social workers in health care settings. *Social work in Health Care*, 48(4), 364-385.
- Kirst-Ashman, K.K., & Hull, G.H., Jr. (1999). *Understanding generalist practice* (2<sup>nd</sup> Ed) Chicago: Nelson-Hall.
- Klein, W. C., & Bloom, M. (1992). Studies of scholarly productivity in social work using citation analysis. *Journal of Social Work Education*, 28(3), 291-299.
- Koeske, G.F., & Koeske, R.D. (1989). Work load and burnout: Can social support and perceived accomplishment help? *Social Work*, 34 (3), 243-248.
- Kottler, J.A. (2003). *On being a therapist* (3<sup>rd</sup> ed.). San Francisco; Jossey-Bass.
- Kutner, N.G., Zhang, R., McClellan, W.M. & Cole, S.A. (2002). Psychosocial predictors of noncompliance in hemodialysis and peritoneal dialysis patients. *Nephrology Dialysis Transplantation*, 17, 93-99.
- Lacson, R. (2008). *Predicting hemodialysis mortality utilizing blood pressure trends*. AMIA Symposium Proceedings. 369-373.

- Landsman, M. (2001). Commitment in public child welfare. *Social Service Review*, 75  
386-419.
- Leggat, J.E. (1998). Noncompliance in hemodialysis: predictors and survival analysis.  
*American Journal of Kidney Disease*, (32) 139.
- Levy, N.B. (Ed.) (1978). *Psychonephrology 1: Psychological Factors in Hemodialysis and  
Transplantation*. Plenum Medical Book Company: New York.
- Liamputtong, P. (2007). *Researching the vulnerable. A guide to sensitive research  
methods*. Thousand Oaks: London.
- Long, J.M., Kee, C.C., Graham, V., Saethang, T.B., & Dames, F.D. (1998). Medication  
compliance and the older hemodialysis patient. *American Nephrology Nurses  
Association Journal*, 25, 43-49.
- Mahoney, M.J. & Lyddon, W. (1988). Recent developments in cognitive approaches to  
counseling and psychotherapy. *Counseling Psychologist*, 16(2), 190-234.
- Martin, A.D. (1982). Learning to hide: the socialization of the gay adolescent.  
*Adolescent Psychiatry*, 10, 52-65.
- Malterud, K. (2001). The art and science of clinical knowledge: evidence beyond  
measures and numbers. *The Lancet*, 358, 397-400.
- Maslach, C. (1977). Burnout: A Social Psychological Analysis. (Paper presented at the  
Annual Convention of the American Psychological Association).
- Maslach, C., & Jackson, E. (1981). *Maslach Burn-out Inventory (research ed.)*. Palo  
Alto, CA: Consulting Psychologists Press.
- Maslach, C., Jackson, S.E., Leiter, M.P., Schaufeli, W.B., Schwab, R.L. (1986) *Maslach  
Burnout Inventory Instrument and Scoring Guides*. Mind Garden, Inc.

- Maslach,C. (1987). Burnout research in social services. *Journal of Social Service Research, 10*(1) 95-105.
- Maslach C. (1993). Burnout: A multidimensional perspective. In W. Schaufeli, C. Maslach, T. Marek (Eds.), *Professional Burnout: Recent Developments in Theory and Research (19-32)*. Washington D.C.: Taylor & Francis.
- Maslach, C., Schaufeli, W., & Leiter, M.P. (2001). Job burnout. *Annual Review of Psychology, 52*, 379-422.
- Mavromates, P. (2005). Physical activity and Chronic Renal Failure. *Dialysis Living, 13*: 22-38.
- Maylon, A.K. (1982). Psychotherapeutic implications of internalized homophobia in gay men. *Journal of Homosexuality, 7*, 59-70.
- McCann, I.L., & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*(1), 131-149.
- McDonald, S.M. (2012). Perception: a concept analysis. *Journal of Nursing Knowledge, 23*(1) 2-9.
- Meijman, T.F., & Mulder, G. (1998). Psychological aspects of workload. In P.J.D. Drenth & H. Thierry (Eds.), *Handbook of work and organizational psychology: Vol.2. Work psychology (pp.5-33)*. Hove, UK: Psychology Press.
- Merighi, J.R., & Ehlebracht, K. (2004a). Issues for social workers in dialysis clinics in the United States. *Nephrology News & Issues, 18*(6), 67-68, 71-75.
- Merighi, J. R., & Ehlebracht, K. (2004b).Issues for renal social workers in dialysis clinics in the United States. *Nephrology News &Issues, 18*(5), 67-73.

- Merighi, J. R., & Ehlebracht, K. (2004c). Unit based patient services and supportive counseling.
- Nephrology News & Issues, 18(6), 55-60.
- Merighi, J.R., Browne, T., Keenan, S. (2009). Emotional exhaustion and workload demands of kidney transplant social workers. *Journal of Nephrology Social Work*, 32.
- Meyers, T.W. & Cornille, T.A. (2002). *The trauma of working with traumatized children*. In C.R. Figley (Ed.), *Treating compassion fatigue* (pp. 39-55). New York: Brunner-Routledge.
- Mid Atlantic Renal Coalition. (1994). Working with noncompliant and abusive patients. End –Stage Renal Disease Network 5, Midlothian, VA. February Issue.
- Miller, R.S. & Rehr, H. (1983). *Social Work Issues in Health Care*. Prentice-Hall: Englewood Cliffs, NJ.
- Mishra, B., Mehta, S.C., Sinha, N.D., Shukla, S.K., Kawatra, A., Kawatra, N. (2011). Evaluation of work place stress in health university workers: A study of rural India. *Indian Journal of Community Medicine*, 36(1): 39-44.
- Monette, D.R., Sullivan, T.J. & Dejong, C.R. (2008). *Applied Social Research: A Tool for the Human Services*. Seventh Edition. Thomson Wadsworth: Belmont.
- Mor Barak, M.E., Nissly, J. A., & Levin, A. (2001). Antecedents to retention and turnover among child welfare, social work, and other human service employees: What can we learn from past research? A review and meta-analysis. *Social Service Review*, 75(4), 625-662.
- Mor Barak, M.E. (2005). *Managing diversity: Toward a global inclusive workplace*. Thousand Oaks, CA: Sage Publications.

- Mor Barak, M.E. Levin, A., Nissly, J., & Lane, C. J. (2006). Why do they leave? Modeling child welfare worker turnover intentions. *Children and Youth Services Review, 28*(5). 548-577.
- Morse, J. M. (2000). Determining sample size.
- Murphy, F. (2004). Stress among nephrology nurses in Northern Ireland. *Nephrology Nursing Journal, 31*(4), 423-431.
- Mukherjee, S., Bereford, B., Glaser, A. & Sloper, P. (2009). Burnout, psychiatric morbidity, and work-related sources of stress in paediatric oncology staff: a review of the literature. *Psycho-Oncology, 18*: 1019-1028.
- Nakahara N., Morita N., Uchida, M. (2004). Nursing care for dialysis patients in Japan. *European Dialysis and Transplant Nursing Association/European Renal care Association Journal, 30*(4).
- National Association of Social Workers (2006). *Social work speaks* (7<sup>th</sup> ed). Washington, DC: NASW Press.
- National Institute for Occupational Safety and health (NIOSH). (2003). Report on stress and work. Retrieved August 15, 2007, from [www.cdc.gov/NIOSH/stresswork/html](http://www.cdc.gov/NIOSH/stresswork/html). In Rai, G.S. (2010). Burnout among long-term care staff. *Administration in Social Work, 34*(3) 225-240.
- Nenner, R. P., Imperato, P.J., & Will, T.O. (1995). IPRO's health care quality improvement program. *Journal of Community Health. 20*(1) 59-64.
- Newell, J.M., MacNeil, G.A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk

- factors, and preventive methods for clinicians and researchers. *Best Practices in Mental Health*. 6(2).
- Newson, J., & Newson, E. (1975). Intersubjectivity and the transmission of culture: on the social origins of symbolic functioning. *Bulletin of the British Psychological Society*. 28, 437-446.
- Nissley, J.A., Mor Barak, M.E., & Levin, A. (2005). Stress, social support, and workers' intentions to leave their jobs in public welfare. *Administration in Social Work*, 29 (1), 79-100.
- Nolph, K.D. (Ed). (1989). *Peritoneal Dialysis*. Third Edition. Kluwer Academic Publishers: Dordrecht.
- Nolph, K.D. (Ed). (1981). *Peritoneal Dialysis- Developments in Nephrology*. Volume 2. Martinus Nijhoff: The Hague.
- O'Donnell, M.L., Creamer, M.C., Parslow, R., Elliot, P., Holmes, A.C., Ellen, S., Judson, R., Mcfarlane, A.C., Silove, D., Bryant, R.A. (2008). A predictive screening index for posttraumatic stress disorder and depression following traumatic injury. *Journal of Consulting and Clinical Psychology*, 76(6), 923-932.
- Oikonomidou G, Zlatanos D, Vayopoulos H, Hatzidimitriou H: Depression in patients with chronic renal failure. (2005). *Dialysis Living*,14: 22-32.
- Onwuegbuzie, A.J. & Leech, N.L. (2007). A call for qualitative power analyses. *Quality & Quantity*, 41 (1), 105-121.
- Orlando, G., Giovanni, G., Zona, S., Menozzi, M., Carli, F., Garlassi, E., Berti, A., Rossi, E., Roverato, A., Palella, F.. (2011). Premature Age-Related Comorbidities

- Among HIV-Infected Persons Compared With the General Population, *Clinical Infectious Diseases*, 53, (11/ 1), 1120–1126.
- Ortlepp, K. and Friedman, M. (2002), Prevalence and correlates of secondary traumatic stress in workplace lay trauma counselors. *J. Traum. Stress*, 15: 213–222.
- Paddison, K. (2002). Complying with pelvic floor exercises: a literature review. *Nursing standard*, 16(39), 33-38.
- Paniagua, R., Amato, D., Vonesh, E., Guo, A., & Mujais, S. (2005). Health-related quality of life predicts outcomes but is not affected by peritoneal clearance, *The ADEMEX trial. Kidney International*, 67(3), 1093-2005.
- Paquin, G. (2006). Including narrative concepts in social work practice classes. *Journal of Teaching in Social Work*, 26 (1/2).
- Perlman, B. & Hartman, E. A. (1982). Burnout: Summary and future research. *Human Relations*, 35, 283-305.
- Perumal, S. & Sehgal, A.R. (2003). Job satisfaction and patient care practices of hemodialysis nurses and technicians. *Nephrology Nursing Journal*, 30(5), 523-528.
- Pines, A.M., Aronson, E. & Kafry, D. (1981). *Burnout: From Tedium to Personal Growth*. New York: Free Press.
- Pines, A.M. (1993). Burnout. In: L. Goldberger & S. Bresnitz (Eds.), *Handbook of stress: Theoretical and clinical aspects* (2<sup>nd</sup> ed., pp. 386-402). New York, NY: Free Press.
- Pines, A., & Maslach, C. (1978). Characteristics of staff burnout in mental health settings. *Hosp. Community Psychiatry*, 29 (4), 233-237.

- Pooler, D.K. (2010). Validation of the Inventory of Professional Functioning (IPF): Occupational Health of Social Workers. *Journal of Workplace Behavioral Health, 25*(1), 19-33.
- Pooler, D.K., Siebert, D.C., Faul, A.C., & Huber, R. (2008). Personal history and professional impairment: Implications for social workers and their employers. *Administration in Social Work, 32* (2), 69-85.
- Prescott, M. (2006). Managing mental illness in the dialysis treatment environment: A team approach. *Nephrology News & Issues, 7*(4), 31-41.
- Pryce, J.G., Shackelford, K.K., & Pryce, D.H. (2007). *Secondary traumatic stress and the child welfare professional*. Chicago: Lyceum Books.
- Radey, M. & Figley, C. R. (2007). The social psychology of compassion. *Clinical Social Work Journal, 35*, 207-214.
- Rai, G.S. (2010). Burnout among long-term care staff. *Administration in Social Work, 34* (3) 225-240.
- Ray, E.B., & Miller, K.I. (1991). The influence of communication structure and social support on job stress and burnout. *Management Communication Quarterly, 4*(4), 506-527.
- Ricoeur, P. (2007). *Reflections on the just*. Translated by D. Pellauer. Chicago: The University of Chicago Press.
- Roberts, J, Johnstone S. (2006). Screening and treating depression: Patient preferences and implications for social workers. *Nephrology News & Issues, 20*(13):43, 47-49.

- Rubin, A. and Babbie, E. R. (2008). *Research Methods for Social Work*, Belmont, CA: Thomson Brooks/Cole. 6th edn.
- Ryan, E. B., Jin, Y., Anas, A. P., & Luh, J. J. (2004). Communication beliefs about youth and old age in Asia and Canada. *Journal of Cross-Cultural Gerontology*, 19(4), 343–360.
- Saleebey, D. (1998). Constructing the community: Emergent uses of Social constructionism in economically distressed communities. In C. Franklin & P. Nurius (Eds). *Constructivism in practice: Methods and challenges*. (291-310). Milwaukee: Families International.
- Saleebey, D. & Saleebey, D. (ed) (1997). *The strengths perspective in social work practice* (2nd ed). Longman, New York.
- Salston, M., & Figley, C.R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress*, 16, 167-174.
- Sandelowski, M. (2004). Using qualitative research-Keynote Address: Tenth Annual QHR. *Qualitative Health Research*. 14:10, 1366-1386.
- Schneider, M. (1991). Developing services for lesbian and gay adolescents, *Canadian Journal of Community Mental Health*, 10, 133-151.
- Schreiber, R. S., & Stern, P. N. (Eds.). (2001). *Using grounded theory in nursing*. Springer Publishing Company.
- Schwaber Kerson, T. (1989). *Social work in health settings: Practice in Context*. The Haworth Press: New York.

- Schwartz, R. H., Tiarniyu, M. F., & Dwyer, D. J. (2007). Social worker hope and perceived burnout: The effects of age, years in practice, and setting. *Administration in Social Work, 31*(4), 103–119.
- Shashar, B., Auslander, G. & Cohen. H. (1995). Utilizing data to improve practice in hospital social work: A case study. *Social Work in Health Care, 20*, 99-11.
- Shulman, L. (2009). *The Skills of Helping Individuals, Families, Groups, and Communities*. Sixth Edition. Brooks/Cole, Cengage Learning: Belmont.
- Schutz, A. *The phenomenology of the social world*. Evanston, IL: Northwestern University Press, 1967.
- Siltaloppi, M., Kinnunen, U., & Feldt, T. (2009). Recovery experiences as moderators between psychosocial work characteristics and occupational well. *Work Stress, 23* (4), 330-348.
- Silverman, D. (1993). *Interpreting qualitative data: methods for analyzing talk, text and interaction*. Sage Publications: London.
- Smetanka, S.L. (2006). Who will protect the “disruptive” dialysis patient? *American Journal of Law and Medicine, 32*(1), 39 -91.
- Smith, B.D. (1998). *Psychology, science and understanding* (International Ed.). New York: McGraw Hill.
- Spaniol, L. & Caputo, J.J. (1978). *Professional burn-out. A survival kit*. Lexington, Massachusetts: Human Services Associates.
- Sprang, G., Clark, J.J., Whitt-Woosely, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: factors impacting a professional’s quality of life. *Journal of Loss and Trauma, 12*, 259-280.

- Stalker, C.A., Mandell, D., Frensch, K.M., Harvey, C., Wright, M. (2007).  
 Child welfare workers who are exhausted yet satisfied with their jobs: How do they do it? *Child and Family Social Work, 12*, 182-191.
- Stav, A., Florian, V., & Shurka, E.Z. (1986). Burnout among social workers working with physically disabled persons and bereaved families. *Journal of Social Service Research, 10* (1), 81-105.
- Stamm, B.H. (2002). *Measuring compassion satisfaction as well as fatigue: Developmental history of the Compassion Satisfaction and Fatigue test.* In C.R. Figley 9ed.), *Treating compassion fatigue* (pp.107-119) New York: Brunner-Routledge.
- Stedman, T.L. (2012). *Stedman's medical dictionary for the health professions and nursing, illustrated.* 7th ed. Philadelphia:Wolters Kluwer Health/Lippincott Williams & Wilkins.
- Stoeckle, J.D. (1983). *Curriculum development and training for health professionals: The job ahead.* In R.S. Miller (Ed.), *Primary health care: More than medicine.* Englewood Cliffs, NJ: Prentice –Hall.
- Strauss, A.L. (1987). *Qualitative analysis for social scientists.* New York: Cambridge University Press. In Charmaz, K. (2006). *Constructing Grounded Theory. A Practical Guide Through Qualitative Analysis.* London:Sage.
- Strolin, J.S., McCarthy, M., & Caringi, J. (2007). Causes and effects of child welfare workfare turnover: current state of knowledge and future directions. *Journal of Public Child Welfare. 1* (2).

- Swartz, R.D., Perry, E., Brown, S., Swartz, J., Vinokur, A. (2008). Patient-staff interactions and mental health in chronic dialysis patients. *Health & Social Work*. (33) 2.
- Symister, P., & Friend, R. (2003). The influence of social support and problematic support on optimism and depression in chronic illness: A prospective study evaluating self-esteem as a mediator. *Health Psychology*. 22 (2), 123-129.
- Sze, W., & Ivker, B. (1986). Stress in social workers: The impact of setting and role. *Social Casework*, 67 (3), 141-148.
- Taylor-Brown, S., Johnson, K.H., Hunter, K., & Rockwitz, R. (1981). Stress identification for social workers in health care: A preventive approach to burnout. *Social Work in Health Care*, 7 (2), 91-100.
- Teitelman, J. L., & O'Neill, P. (2001). Adult development and aging: A model continuing education course for practicing social workers. *Journal of Gerontological Social Work*, 35 (4), 57-67.
- The Career Project Interactive Research Database, CNN (Cable News Network) (October 2, 2012)
- Thompson, L.E., Hess, H.J. (1989). The intergration of primary health care and social work in the educational setting. Ed. Matthew Henk. *Social Work in Primary Care*. Sage Publications: Newbury Park, CA.
- Tijerina, M.S. (2009). Mexican American women's adherence to hemodialysis treatment. *Social Work*. 54:3, 232-241.
- Time Magazine (1976). Medicine: kidney in a suitcase. Monday, January 5, 1976 edition. Time.com

- Tinius, T.P. (1988). Help for impaired psychologists and social workers? : A survey of state psychological associations and state chapters of the National Association of Social Workers. *Journal of Training & Practice in Professional Psychology*. 2 (1) 25-34.
- Tosone, C. (2006). Therapeutic intimacy: A post-9/11 perspective. *Smith College Studies in Social Work*, 76(4), 89-98.
- Tramo, J.G. (1978). The Nephrology Social Worker as the Primary Psychological Practitioner. In Levy, N.B. (Ed.) (1978). *Psychonephrology 1: Psychological Factors in Hemodialysis and Transplantation*. Plenum Medical Book Company: New York.
- Trippany, R.L., Kress, V.E.W., & Wilcoxon, S.A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling and Development*, 82, 31-37.
- Tucker, C.M. (2010). End stage renal disease patients and dialysis: Can consistent transportation influence quality of life and treatment compliance? A grant writing project. California State University, Long Beach. (thesis).
- Troiden, D. R. R. (1989). The formation of homosexual identities. *Journal of homosexuality*, 17(1-2), 43-74.
- Tsay, S.L. (2003). Self-efficacy training for patients with end stage renal disease. *Journal of Advanced Nursing*, 43 (4), 370-375.
- Um, M.Y., & Harrison, D.F. (1998). Role stressors, burnout, mediators, and job satisfaction: A stress strain-outcome model and an empirical test. *Social Work Research*, 22 (2), 100-115.

- Uribe, V., & Harbeck, K.M. (1992). Addressing the needs of lesbian, gay, and bisexual youth: the origins of Project 10 and school-based intervention. *Journal of Homosexuality*, 22, (3/4), 9-27.
- United States National Oceanic and Atmospheric Administration. National Weather Service, May 2013. <http://www.noaa.gov/weather>.
- United States Renal Data System, USRDS (2010). Annual Data Report: Atlas of Chronic Kidney Diseases and End Stage Renal Disease in the United States. National Institute of Health. National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD.
- van der Doef, M., & Maes, S. (1999). The job demand control (-support) model and psychological well being: A review of 20 years of empirical research. *Work & Stress*, 13, pp. 87-114.
- van Vegchel, N., de Jong, J., Bosma., & Schaufeli, W. (2005). Reviewing the effort-reward imbalance model: Drawing up the balance of 45 empirical studies. *Social Science & Medicine*, 60, pp. 1117-1131.
- Vergara, T.L. (1984). Meeting the needs of sexual minority youth: One program's response. In R. Scoenberg & R. Goldberg (Eds.), *Homosexuality and social work* pp.19-38. New York: Haworth.
- Vourlekis, B., Ell, K. (2007). Best practice case management for improved medical adherence. *Social Work in Healthcare*. 44 (33) pp. 161-177.
- Vygotsky, L. (written 1934: published 1962). *Thought and language*. Cambridge: MIT Press.

- Vygotsky, L. (1978). Interaction between learning and development. *Readings on the development of children*. 23 (3), 34-41.
- Walker, L.O., & Avant, K.C. (2005). *Strategies for theory construction in nursing* (4<sup>th</sup> Ed.). Upper Saddle River, NJ: Pearson/Prentice Hall.
- Weber, M. *Economy and society: an outline of interpretive sociology*. Vol.1. New York: Bedminster Press, 1968.
- Wendt, C., Mischke, M., Pfeifer, M. (2011). *Welfare states and public opinion. Perceptions of healthcare systems, family policy and benefits for the unemployed and poor in Europe*. Northampton: Elgar.
- Wu AW, Fink NE, Marsh-Manzi JV, Meyer KB, Finkelstein FO, Chapman MM, Powe NR: Changes in quality of life during haemodialysis and peritoneal dialysis treatment: Generic and disease specific measures. *Journal of American Society of Nephrology*. 2004, 15: 743-53.
- Yankeelov, P.A., Barbee, A. P., Sullivan, D. and Antle, B. F. (2009). Individual and organizational factors in job retention. *British Journal of Social Work*. 36 (5), 777-788. subject index 251.
- Yokoyama, Y., Suzukamo, Y., Hotta, O., Yamazaki, S., Kawaguchi, T., Hasegawa, T., Chiba, S., Moriya, T., Abe, E., Sasaki, S., Haga, M., Fukuhara, S. (2009). Dialysis staff encouragement and fluid control adherence in patients on hemodialysis. *Nephrology Nursing Journal*. 36 (3).
- Zischka, P.C. & Fox, R. (1983). Burnout and the catalytic role of the supervisor. *The Clinical Supervisor*, 1:2, 43-52.

Zlotnick, C., Najavits, L.M., Rohsenow, D. J. (2003). A cognitive-behavioral treatment for incarcerated women with substance use disorder and posttraumatic stress disorder: Findings from a pilot study. *Journal of Substance Abuse Treatment*. 25: 99-105