AN INVESTIGATION OF BURNOUT AMONGST MEDICAL SOCIAL WORKERS WORKING IN CHILDREN'S WARDS

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

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ABSTRACT

Medical social workers working in children's wards are more prone to burnout because of the stressful nature of their work. Because social work requires emotional involvement, it is not uncommon for workers to be emotionally drained and frustrated, which might lead to burnout. Stress amongst social workers is an important issue, as a stressed workforce can negatively affect the quality of service. This study was undertaken with the aim of providing guidelines for handling stress amongst medical social workers working in children's wards, in order to promote job satisfaction and enhance work performance.

Chronically ill children who are hospitalised, often suffer from behavioural and emotional problems that require social work intervention, which in turn puts pressure on the social worker. Concurrent stressors on the children and their families may exhaust their normal coping capacity and further complicate the child's adaptation to hospitalisation. The role of the medical social worker is to provide social support to the child and the family in order to promote positive coping in the child during and after hospital treatment. The demands put on the social worker by hospitalised children can cause stress, which could adversely affect their work performance and job satisfaction.

Social workers therefore, have to carefully select an appropriate practice framework when dealing with hospitalised children. This entails the selection of appropriate perspectives, theories and models to ensure effective intervention. These frameworks provide structure and directive to social work intervention, and combined with supervision, can promote job satisfaction amongst medical social workers.

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The study was undertaken amongst medical social workers working in paediatric wards within hospitals in the Cape Metropolitan area. The empirical study focused on an investigation of factors, which might contribute to the experience of burnout amongst the social workers. Work-related stressors play a major role in increasing the likelihood of burnout amongst social workers. If these stressors are not properly dealt with they might lead to burnout amongst medical social workers, which will have a direct bearing on the child's benefit from medical services. A combination of both organisationally based and individually based strategies should be implemented in order to overcome job-related stress and to prevent burnout.

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OPSOMMING

Mediese maatskaplike werkers wat in kindersale werk, is meer geneig tot uitbranding as gevolg van die stresvolle aard van hulle werk. Maatskaplike werk vereis emosionele betrokkenheid. Dit is dus nie ongewoon vir maatskaplike werkers om emosioneel gedreineerd en gefrustreerd te voel nie. Laasgenoemde is kenmerke van uitbranding. Oormatige stres by maatskaplike werkers kan 'n negatiewe uitwerking op die kwaliteit van hul dienslewering hê. Hierdie navorsingstudie was onderneem met die oog op die daarstelling van riglyne vir die hantering van stres by mediese maatskaplike werkers, wat in kindersale werk om sodoende werkstevredenheid en -verrigting te bevorder.

Kroniese siek kinders wat gehospitaliseer word, presenteer dikwels met gedrags- en emosionele probleme wat uiteraard tydens intervensie addisionele druk op die maatskaplike werker plaas. Gepaardgaande stressors kan daartoe lei dat pasiënte en hul gesinne afwyk van hul normale funksionering wat weer die pasiënt se hanteringsvermoë en aanpassing by die hospitaalopset belemmer. Die rol van die mediese maatskaplike werker is om sosiale ondersteuning aan bogenoemde partye te gee ten einde positiewe hanteringsvermoë tydens en na mediese behandeling, by pasiënte te vestig. Die eise wat deur pasiënte aan maatskaplike werkers gestel word kan stres veroorsaak wat hul werksverrigtinge en tevredenheid negatief kan affekteer.

Maatskaplike werkers moet dus versigtig te werk gaan in die keuse van 'n gepaste praktykraamwerk vir intervensie ten opsigte van gehospitaliseerde kinders. 'n Verantwoordbare keuse van perspektiewe, teorieë en modelle lê ten grondslag van effektiewe maatskaplike werk intervensie. Hierdie raamwerke bied struktuur en rigting aan maatskaplike werk intervensie. Laasgenoemde, tesame met

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supervisie kan werkstevredenheid onder mediese maatskaplike werkers bevorder.

Stressors wat met werk verband hou, speel 'n groot rol in die toename van uitbranding onder mediese maatskaplike werkers. Indien hierdie stressors nie effektief hanteer word nie, kan dit tot uitbranding by maatskaplike werkers ly wat dan weer die pasiënt se benutting van mediese dienste negatief beïnvloed. Die ondersoekgroep het bestaan uit tien mediese maatskaplike werkers wat werksaam was in paediatriese sale in hospitale binne die Kaapse Metropool. Tydens 'n empiriese ondersoek is gefokus op faktore wat moontlik aanleiding kan gee tot die uitbranding van maatskaplike werkers.

Dit word dus aanbeveel dat 'n kombinasie van strategieë van beide die organisasie en die persoon geïmplementeer moet word om werksverwante stres te oorkom en dus uitbranding by mediese maatskaplike werkers te voorkom.

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CHAPTER ONE
INTRODUCTION

1.1 MOTIVATION FOR THE STUDY

Social workers employed in child care services and health care settings have been found to have significantly higher stress outcomes, greater perceived stress and emotional exhaustion when compared to those workers in other fields of the social work service (Bennet, Evan & Tattersall, 1993:41; Siefert, Jayaratne & Chess, 1991:193). Social workers dealing with children in hospital can be regarded as working in a combination of the two aforementioned fields of service, hence the incidence of high stress levels.

Certain factors contribute to the development of stress, which manifests itself in different ways in individual social workers. Bennett *et al.* (1993:33) described stress as resulting from a disparity between the demands made upon an individual and his/her ability to cope with those demands. Stress is a process that involves a number of distinct, but interacting, factors. These factors relate to environmental demands, the perception of those demands, the coping resources available to the individual, and the emotional outcome of these demands (Bennett *et al.*, 1993:33).

The annual statistics from the Red Cross Children's Hospital where the researcher works, show that the total number of children admitted to the Hospital during the financial year from April 2002 to March 2003 was 19 243. During the last six months of the same financial year a total of 2 025 patients were dealt with by the seven social workers working at the Hospital. This meant that each social worker had a total monthly work-load of about 48 patients. These statistics indicate a large work-load, which is unlikely to decrease due to the regular admission of patients to public hospitals. The increase in work-load is potentially stressful for the social worker. This finding is supported by several

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authors who have identified work-load as one of the factors contributing to stress amongst social workers (Davies, 1998; Collings & Murray, 1996; Jones, Fletcher & Ibbetson, 1991; Gibson, McGrath & Reid, 1989). Social workers at the Red Cross Children's Hospital deal with problems arising from the following: assessment of patients for organ transplants, child abuse, children with terminal illnesses, behaviour problems, attempted suicides and consent issues. All these problems have an emotional content and are therefore potentially stressful.

Frequent hospitalisation of chronically ill children is potentially stressful to them and stress was identified as primarily responsible for increasing the risk of adjustment problems in ill children (Eiser & Main, 2000:12). The medical social worker's role is to provide emotional support for the child and the family in order to promote adjustment to, and therefore optimum benefit from medical care. To this end, the medical social worker has to understand the factors that influence the child's adaptation to hospitalisation. Before intervention the social worker needs to assess fully the child's functioning within the family, as this functioning will affect the child's experience and ability to cope (Scheepers, 1994:10).

The role of the medical social worker also involves advocating the cause of the children and their families in the multi-disciplinary team. Dissension occurs when the medical professionals form an opinion based on medical grounds and families make opposing decisions based on their religious convictions and beliefs (Horn, Feldman & Ploof, 1995:124). Striking a balance between the social work practice and organisational priorities is very difficult to accomplish (Donnelly, 1992:108) and might compromise the social worker's working relationship and role within the team, which could in turn increase stress.

Stress amongst social workers is an important issue because a stressed workforce cannot render effective service to the community (Collings & Murray,

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1996:375). This study will investigate job related stress as experienced by medical social workers, and inherent in the situation of hospitalised children (Collings & Murray, 1996; Thompson, Murphy & Stradling, 1994). Job related stress could develop into burnout if it is not properly managed and this could in turn decrease the level of job satisfaction amongst medical social workers. This is supported by several authors who identified burnout as a serious form of occupational stress that can impair the worker's effectiveness (Collings & Murray, 1996; Kadushin, 1992, Gibson *et al.*, 1989;). As a result of burnout, social workers develop negative self-concepts, negative job attitudes and less concern for clients, hence the likelihood of decreased job satisfaction.

Siefert *et al.* (1991:194) identified potential stressors inherent in job characteristics of the medical social workers. These job characteristics are role conflict, role ambiguity, challenge, work-load, comfort, value conflict, financial rewards, promotional opportunities and job satisfaction. Increased work-loads prevent medical social workers from conducting a proper follow-up of the patients once they are discharged. Louw *et al.* (1999:311) agrees that, due to work-load, the medical social workers find it impossible to follow up cases to determine whether the child was given the necessary attention by the welfare agencies they were referred to. Medical social workers therefore are often not able to receive feedback or see the end result or output once the patients are discharged and this could result in feelings of frustration and meaninglessness, which are associated with burnout.

Several authors agreed that having too much administrative work and too little information can be significantly associated with higher levels of stress among social workers (Collings & Murray, 1996; Jones *et al.*, 1991). The most commonly cited stressors were too much work, the pressure involved in planning and reaching work targets, having too little time to perform duties or manage administration and lack of resources (Collings & Murray, 1996:383; Jones *et al.,* 1991:453; Gibson *et al.*, 1989:8). These authors concluded that

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having a large work-load and very little time in which to do it, might contribute to job-related stress among social workers. Social workers therefore need to find effective mechanisms to deal with stress.

The motivation to undertake this study arose out of the personal experience of the researcher working as a social worker in a children's hospital. The researcher is interested to determine strategies that medical social workers can utilise to promote job satisfaction and to reduce stress. The researcher was also inspired by a recommendation made by Hartweg (2000:89) namely that further research be conducted on stress experienced by social workers and the effect of supervision or assessment of abused children. The effect of stress has been identified as very significant in a number of professions, including social work (Gibson *et al.*, 1989:3) but research on stress among social workers is limited. This study will formulate guidelines for managing stress experienced by medical social workers working with hospitalised children. The guidelines will promote the use of positive coping mechanisms and strategies to promote job satisfaction in order to improve service.

1.2 AIMS OF RESEARCH PROGRAMME

The aim of the study is to provide guidelines for handling stress among medical social workers working with hospitalised children in order to promote job satisfaction and enhance work performance.

1.2.1 Objectives

- To identify the experience of a hospitalised child and factors that influence the child's adaptation to hospitalisation.
- To describe social work intervention with hospitalised children and the factors contributing to burnout in medical social workers.
- To investigate the experiences of burnout amongst medical social workers working in children's wards.

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1.3 THE RESEARCH AREA

The study was conducted in the major hospitals in the Cape Metropolitan area. The target group was the medical social workers working in paediatric wards in these hospitals. The reason for choosing this area was that these hospitals function as major referral facilities serving the Cape Town city bowl, the southern suburbs and the Cape Flats. Owing to the size of this, medical social workers are exposed to large case loads and a diversity of problems, which can increase the work-load and contribute to stress. To ensure confidentiality, the hospitals will not be identified for as there are many hospitals in this area, only a few have paediatric wards. There are only a few social workers operating in the research area and identifying the specific hospitals would make it easy to identify the respondents, who were assured of anonymity. According to Rubin and Babbie (1993:317) emphasis on confidentiality and anonymity ensures greater participation in the study.

1.4 RESEARCH METHODOLOGY

1.4.1 Type of research

The study made use of an exploratory research design. The reason for using this design is that very little is known about the topic (De Vos, 1998). The researcher wanted to establish general ideas and preliminary theories which can be explored later with more precise and hence more complex research designs (Grinnell, 1988:225). The exploratory research design will therefore contribute to a greater understanding of the topic and assist in identifying areas which need further research.

The researcher used both qualitative and quantitative methods to obtain the data, as all findings must ultimately be recorded either in words or schematically (De Vos, 1998:15). This in turn gives more clarity about the findings and makes it easy to interpret them. By means of questionnaires, the researcher gathered more facts that were then presented using a quantitative method of data processing.

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1.4.2 Sample

The sample, consisting of ten medical social workers working in children's wards, was selected using a purposive sampling method. This method is based on the researcher's own knowledge of the characteristics of the population group, and the nature of the research aims (Rubin & Babbie, 1993:255). The area under consideration was limited to those hospitals with paediatric wards. Although these hospitals had large (28) numbers of medical social workers, the number of respondents was further narrowed down to those assigned to paediatric wards.

1.4.3 Measurement instrument

The respondents were asked to complete questionnaires. The use of self-administered questionnaires is one of the data collection methods of a quantitative approach (De Vos, 2001:89; Grinnell, 1993:189;). Participation in the research was voluntary and the information was kept confidential by the researcher. The questionnaires contained both open-ended and closed-ended questions, which assisted the researcher in a greater exploration of the topic, leading to a more comprehensive report.

1.5 LIMITATIONS OF THE STUDY

Despite the large number of social workers employed in hospitals in the Metropolitan area, only a few work in the paediatric wards, which limited the number of participants a great deal. The researcher was also a medical social worker in one of the hospitals and to avoid biased results could not participate in the study. Owing to the small sample, the findings of this study cannot be generalised.

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1.6 DEFINITIONS

For the purposes of the study the following definitions apply:

- *Assessment*: "process of analysing the factors that influence or determine the social functioning of the individual, family, group or community" (New Dictionary of Social Work, 1995:4).
- *Burnout*: "A condition that results from work-related stress and frustration and is characterised by varying degrees of depression and apathy" (New Dictionary of Social Work, 1995:6).
- *Child*: According to the Child Care Act 74 of 1983 a child is " any person under the age of 18 years".
- *Crisis*: "Disruption of the emotional balance or an established way of living of an individual" (New Dictionary of Social Work, 1995:16).
- *Medical social worker*: refers to a social worker that works in a hospital setting. (For the purpose of this study, "social worker" refers to the medical social worker.)
- *Stress*: "Totality of physical and psychological reactions to detrimental internal and/or external stimuli, characterised by the disturbance of the homeostasis between individuals and environment" (New Dictionary of Social Work, 1995:63).
- *Stressor*: "Event or process which, because of its demands on people, brings about a change in their bio-psychosocial condition and influences their social functioning, should internal and external resources not be able to provide for their needs" (New Dictionary of Social Work, 1995:63).

1.7 CONTENT OF THE RESEARCH

The following aspects will be discussed in the remaining chapters of the thesis:

- Chapter 2 focuses on the hospitalised child and the factors affecting the child's adaptation to hospitalisation.
- Chapter 3 describes social work intervention with hospitalised children and the factors contributing to burnout in medical social workers.
- Chapter 4 contains the results of the empirical study.
- Chapter 5 contains the conclusions and recommendations.

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CHAPTER TWO
THE HOSPITALISED CHILD

2.1 INTRODUCTION

A child who is admitted to hospital faces a variety of challenges and issues that he or she has to deal with in order to adapt to the hospital setting. Having to adjust to an unfamiliar environment, being separated from familiar figures and the threat of pain and physical discomfort all contribute to make hospitalisation an unpleasant and stressful event (Bonn, 1995:18). Studies done on hospitalised children (Bonn, 1995; Bennet, 1994; LaGreca, 1990) identified chronic illness and hospitalisation as a potential stressor. Chronically ill children have also been found to suffer from an increasing number of behavioural and emotional problems.

However, the admission of a child to hospital is nowadays considered to be less traumatic (Chandler, Claridge & Lee, 1990:140). This is attributed in general to establishing paediatric wards in hospitals which are bright, have playrooms without abundant toys and where regular visiting by the parents is encouraged. Efforts are made to ensure some continuity between home and hospital (Eiser & Main, 2000:10). Despite these improvements in the care of children in hospital, it still remains a frightening experience for the child.

A medical social worker plays a very important part in helping children adjust to hospitalisation. When children experience adjustment problems it might negatively affect their treatment, which will in turn influence their recovery. In order to provide effective service the medical social worker has to be aware of certain aspects relating to the child's experience of hospitalisation and how they could influence the child's adaptation to the hospital.

Furthermore, in order to fulfil the child protection and advocacy roles, the social worker has to be aware of the relevant policy and legislation with regard

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to children in hospital. Policy and legislation pertaining to children in hospital will therefore be discussed in the next section.

2.2 POLICY AND LEGISLATION PERTAINING TO CHILDREN IN HOSPITAL

Section 28(c) of the Constitution of the Republic of South Africa, Act 108 of 1996, states that access to basic health care services is a right for every child in South Africa. Health care practitioners in hospitals make various decisions concerning children's health, which might have long-term consequences. Due to the huge responsibility involved in the decision-making processes concerning the child's health it is essential for medical social workers to acquaint themselves with the relevant legislation.

Legislation provides guidelines for social workers when explaining decisions taken by the health practitioners on the children's behalf. Children are also protected by legislation to ensure that the care and treatment given is not a matter of personal choice of the health practitioner. Legislation also assists the medical practitioners in decisions about whom to involve in the child's medical treatment, and when to involve the child in the decision making process. The protective and advocacy role of the social worker in rendering services to children in hospital is therefore guided by the legislation and it is within this context that the legislation on consent to medical treatment or surgical intervention and child protection will be explained.

2.2.1 Consent to medical treatment or surgical intervention

Section 39(4) of the Child Care Act 74 of 1983 describes certain procedures that should be followed in relation to the decision-making process and setting of boundaries with regard to consent to medical treatment or surgical intervention. The Act states that "consent must be obtained by a registered medical practitioner for a child under 14 years of age, from the parent of the child or legally responsible person". Children who are over the age of 14 years are regarded as competent to give consent without the assistance of parents or

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a legal guardian, to the performance of any medical treatment upon themselves or their children.

Section 39(4) of the Child Care Act 74 of 1983 also states that if a medical practitioner wants to perform an operation or treatment upon a child, which may not be applied without consent of the parent or guardian, he/she shall report the matter to the Provincial Minister. The Minister may, if satisfied that the operation or treatment is necessary, consent on behalf of the parent or guardian. Consent may only be granted if the parent or guardian refuses consent to a life-saving operation or treatment; cannot be traced; is by reason of mental illness unable to give such consent, or is deceased.

The powers of granting consent vested in the Minister have been delegated to the assistant directors of the district offices of the Department of Social Services. The medical social worker has to ensure that consent relating to the above-mentioned situations is obtained in accordance with the protocol described in section 39(4) of the Child Care Act 74 of 1983. The medical social worker has to conduct an investigation to confirm the absence of the parents or legal guardian. The social worker also has to liaise with the relevant assistant directors at the Department of Social Services to ensure that consent for the operation or treatment is granted on behalf of the affected child.

The investigation may enable the social worker to assess the home circumstances of the child. If the social worker discovers that the child is neglected or at risk, he/she would have to protect the child from such potentially dangerous home circumstances. The legislation with regard to the child protection role of the social worker is clarified below.

2.2.2 Child protection

When children are admitted to hospital due to possible child abuse, the social worker has to spend some time investigating the alleged abuse and assess if it

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would be safe to discharge the child into the care of the parents. Following the correct protocol is of the utmost importance when making decisions regarding child protection because of the long-term consequences for the child. The decisions and actions taken by the medical social worker are guided by the Child Care Amendment Act 96 of 1996. This Act compels all those involved in the care of children to report cases of child abuse to the Director-General of the Department of Social Services.

Various authors (Davies, 1998; Chandler *et al.,* 1990) identified child protection as an area in social work intervention that is very stressful and time-consuming. Child protection is potentially stressful because the social worker at times has to remove the child from the care of the parents or guardian if the child is considered to be at risk. Child abuse cases are reviewed by a multi-disciplinary team, with the social worker functioning as the case manager within the team. The social worker has the task of collating whatever information is necessary to help all the professionals involved in reaching a decision as to the action necessary to protect the child (Chandler *et al.*, 1990:149). This task can be emotionally draining to the social worker, as the onus of implementing the decision taken is left with him or her and can result in the social worker being seen as the bad person by the child's parents and family members.

Children's experience of, and ability to adapt to, hospitalisation are largely determined by a number of factors.

2.3 FACTORS THAT INFLUENCE THE CHILD'S ADAPTATION TO HOSPITALISATION

The experience of hospitalisation is different and unique for every individual child depending, to some extent, on the child's perception of the illness. Edwards and Davis (1997:29) and Sheafor, Horesji and Horesji (1994:419) agreed that an understanding of how children think, especially in terms of their

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age and developmental stages is an important factor influencing children's adaptation to hospitalisation. Other factors include the ways in which the illness imposes physical restrictions; the characteristics of the illness and how the illness is perceived.

2.3.1 Intellectual capacities

Children of different ages understand the causes and consequences of illness differently depending on their stage of development. Edwards and Davis (1997:39) identified age as one of the important factors affecting the child's experience and coping resources while in hospital. For the purposes of this study the following age groups will be examined: three to six years and six to 12 years. Louw and Edwards (1993:516) classified these groups into two developmental stages called early and middle childhood. These age groups were chosen partly because Red Cross Children's Hospital only caters for children up to the age of 12 years. Furthermore, the medical social worker would not be able to execute direct intervention with neonates or infants due to their limited cognitive development. During the neonate and infancy stages the child's major developmental tasks are centred on the co-ordination of the motor activities and sensory input (Louw & Edwards, 1993:509). Social work intervention would therefore not occur directly with the children but only with the parents. Being in the early or middle childhood stages of development will determine a child's intellectual capacity and therefore his adaptation.

2.3.1.1 Early Childhood

Children in the early childhood stage are very subjective, concrete and egocentric (Sheafor *et al.*, 1994:418). Their thinking is characterised by an "all or nothing" tendency, when something is seen as either exclusively good, or bad. Sheafor *et al.* (1994) and Louw and Edwards (1993) agreed that children in this stage only observe events from their own perspective. These children cannot place themselves in another's position or consider consequences of their own actions. During this stage children have a limited ability to reason and

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understand the cause of illness in terms of human activity (Hergerather & Rabinowitz, 1991:954). They perceive illness as a direct result of their misbehaviour.

In early childhood, children are not capable of thinking completely logically and this could have particular implications when trying to encourage adherence to treatment procedures, especially when the results are long-term in nature (Edwards & Davis, 1997:39). Children in this stage have not yet acquired the capacity for abstract thought and do not have a long-term perspective. For example, a child with cancer might refuse treatment because he might not be able to understand that in order to get better he would have to undergo painful chemotherapy treatment. He might have difficulty understanding the difference between illness-related pain and treatment related pain.

The medical social worker has to explain the illness and its possible consequences to the child (Berger, 1994:14). Children in the early childhood stage represent a greater challenge for the social worker because these children do not yet understand the cause-effect relationship. The child might perceive the medical social worker as contributing to the pain experienced during treatment. This could make it difficult for the social worker to establish a trusting relationship with the child, which is an essential aspect of social work intervention. It would also complicate the task of the social worker when trying to convince the child that certain treatment procedures would be for his own benefit. The social worker is torn between the knowledge that the child needs the (painful) treatment in order to survive, and a desire to maintain a trusting relationship with the child and not to be seen as causing pain.

By the age of six years, children are able to express emotions in a more controlled way and are learning to conform to social norms (Louw & Edwards, 1993:521). Children are often separated from their parents due to the long period of hospitalisation. Researchers (Berger, 1994:16; Lewandowski &

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Baranoski, 1994; Louw & Edwards, 1993;) are in agreement that separation and deprivation during the pre-school period are traumatic and have serious consequences for children in the early childhood stage. Without professional intervention, traumatic events can negatively affect the child's psychological and physical health as well as his development (Lewandowski & Baranoski, 1994:527) compounding the problems experienced in the hospital setting.

As children move towards middle childhood however, certain changes occur with regard to their cognitive, emotional and social development, all of which determine their experience of hospitalisation.

2.3.1.2 Middle childhood

Children's thinking becomes more objective and logical during middle childhood (Sheafor *et al.*, 1994:418). During this stage children gradually acquire the ability to imagine themselves in the role of another person and understand that they are not responsible for other people's behaviour. Children in this age group might be able to understand the cause as well as the long-term effects of their illness and might comply with instructions regarding their treatment. This understanding of their illness and its cause, perceived as being behavioural in nature, changes to become more focused on the biological causes of illness (Hergerather & Rabinowitz, 1991:956). They are likely to understand that an illness is not a punishment for misbehaviour, if the illness is adequately explained to them. For example, a child who was involved in a car accident might be able to understand that the reason for his leg being amputated was to save him from a fatal infection and not to punish him.

According to Sheafor *et al.* (1994:418), a child older than ten views himself as a separate person with unique characteristics and abilities. Children in this age group have the ability to reflect on their own experiences and feelings and might also have a clear understanding of the situations around them. They are able to feel and express a greater variety of emotions. These children

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understand that it is possible and normal to experience mixed emotions (Sheafor *et al.*, 1994; Louw & Edwards, 1993). For example, a child might feel afraid and distressed about being in hospital but at the same time feel relieved and safe because he or she wants to become better.

On the other hand, the child might also have ambivalent feelings about being discharged from hospital. Lewandowski and Baranoski (1994:526) argued that for some children who have experienced a traumatic event, a hospital comes to represent safety and security from the threatening forces of the outside world. Despite the ability to express his feelings, it might be difficult for the social worker to normalise the ambivalence experienced by the children. As a result a child might become confused and difficult for the medical social worker to work with. The social worker therefore needs to encourage children to express their feelings. During the initial assessment of the child the medical social worker has to put the child at ease and create an atmosphere that will encourage the child to express himself freely (Scheepers, 1994:12). The social worker has to try and establish a rapport which will develop into an increasingly mutual involvement (Barker, 1990:31). If the child is not comfortable he might not open up to the social worker, which could hinder social work intervention, with negative consequences for treatment and recovery.

During the middle childhood stage children's cognitive skills develop a great deal, as the majority of them spend a large proportion of the day at school. Louw and Edwards (1993:529) argued that children who have had little social experience outside the home might find it more difficult to cope in an unfamiliar environment such as the hospital. However, children who have gained some independence from their parents may find it easier to understand the implications and long-term effects of their illness and are likely to comply with treatment. On the whole, parental homes are still the places that offer the most security and families still have a great influence in children's lives during the middle childhood stage (Louw & Edwards, 1993:533).

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The role of the medical social worker is to provide social support to the child and the family. This provision of social support has a positive effect on the adjustment of the parents and the child during and after hospital treatment (Baider, Cooper & Kaplan De-Nour, 1996:94). The availability of both social and professional support plays a very important part in the family's as well as the child's adaptation. If social support is not available to the parents, the social worker needs to intervene by either offering support to the family, or putting them into contact with the appropriate resources in the community. The parent-professional relations are very important to the enhancement of family coping (Horn *et al.*, 1995:122), which in turn affects the child's handling of and ability to adapt to hospitalisation. A family that is able to deal with the child's illness is likely to have a positive affect on the child's coping abilities. Shields *et al.* (1995:51) argued that the social worker's intervention helps the families maintain equilibrium, mobilises their existing informal support network and facilitates the utilisation of existing resources.

For the most part, it seems that hospitalisation challenges the developmental and everyday tasks of the child in both the early childhood and middle stages of development.

2.3.2 Physical restrictions

The nature and effect of an illness might also compromise and impair children's daily functioning. Some authors (Eiser & Main, 2000; LaGreca, 1990) agreed that the challenges brought about by the illness have both psychological and social implications for the child. Bennet (1994:149) identified psychological problems experienced by chronically ill children, which include increased rates of behavioural and emotional problems. Physical limitations associated with the illness were also identified as one of the possible reasons for these problems (Bennet, 1994:150). Physical limitations include being confined to a hospital bed or environment, which also discourages planning for future activities.

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This restriction limits the child's ability to play or to engage fully in peer activities (LaGreca, 1990:293). Research has indicated that play has a significant influence on the following aspects of the child's development: physical, cognitive, social, emotional and development of the self-concept (Louw & Edwards, 1993:524). Through play children are able to explore new ground, investigate their environment and learn to solve problems. Social interaction with peers is of particular importance in a child's social development, creating opportunities to learn appropriate social rules and behaviours (Meijer, Sinnema, Bijstra, Mellenbergh & Wolters, 2000:309).

Children who do not engage in age appropriate tasks due to limitations imposed by illness, might experience difficulties in their cognitive and social development, which might bear long-term consequences in adulthood. To prevent problems such as self-doubt or a low self-esteem, Meijer *et al.* (2000:316) suggested intervention programmes to improve social skills of children with chronic illnesses. However, implementing such programmes could be difficult for the social worker because the physical limitations of the hospitalised children might prevent them from participating fully in the suggested activities.

In order to understand the experience of a child in hospital, it is important to look at the child's interpretation and understanding of the illness.

2.3.3 Understanding the illness

A child's understanding of an illness depends on his individual experiences of hospitalisation. Chronically ill children's experiences differ from those of acutely ill children. Spirito, Stark and Tyc (1994:320) ascribed the differences to the fact that acutely ill or injured children are mostly hospitalised for the first or only time, whereas chronically ill children usually have recurring hospitalisation experiences.

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According to Eiser and Main (2000:9), many children learn about their illness following hospitalisation for acute or minor injury, and chronically ill children may learn about and understand their illness due to the prolonged experience of living with the illness. It is however, very important for children to know as much as possible about their illness because children who are informed about their condition have been found to be less depressed (Bennett, 1994:162). There is some evidence (Eiser & Main, 2000:21), that children who adjust well are those who are told about their illness at the time of diagnosis or shortly thereafter.

In most cases it is the parents who are informed by the doctor about the child's condition and the decision to inform the child depends on them. As late as the 1960s it was considered advisable that children should not be informed about their illness or involved in decision-making about alternative treatments (Eiser & Main, 2000:21). However, the Child Care Act 74 of 1983 makes provision for children to be included in the decision-making about their medical treatment.

Children differ from adults in their understanding of the cause, treatment and implications of their illness. A child's understanding of the illness is also influenced by specific characteristics of the illness.

2.3.4 Characteristics of the illness

The characteristics that might affect children's grasp of their illness relate to its severity, visibility, aetiology, course, rarity and the nature of the treatment involved (Edwards & Davis, 1997:14). The child's experience of hospitalisation might be affected in a negative way if the disease is chronic, physically disabling or has visible characteristics. For example a child who has been diagnosed with cancer, who has had to undergo treatment in hospital for several months undergoing treatment and ended up having a leg amputated is

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likely to have major difficulties understanding the illness, adapting to the hospital setting, as well as adhering to treatment.

Treatment procedures that could affect a child's physical appearance have also been identified as playing a role in influencing a child's adaptation to hospital (LaGreca, 1990:293). Examples of such treatment procedures are chemotherapy that is used to treat cancer patients, which results in hair loss and corticosteroid medications used for renal transplant patients, which cause puffy facial features. As a result of such physical changes, children might refuse to continue with these treatment procedures.

The unpredictability and uncertainty of an illness is an important issue, which might affect and contribute to the child's experience of hospitalisation. An example is aplastic anemia, which is an unpredictable type of cancer. The cause of this cancer is unknown and treatment requires a bone marrow transplant, which can only be obtained from a child's full siblings, provided their blood groups match. Even if the appropriate donor is found there is still a chance that the child might suffer a relapse. In some cases the treatment might not be effective and the child might eventually die. An illness that bears high risks due to a poor prognosis has the potential to increase the stress levels of the child.

The social worker might also be in a stressful position when asked by a child about the illness, especially if it is terminal. The role of the social worker also involves bereavement counselling, when the social worker must enter into the child's personal world and share it empathetically (Vos, 1997:40). The social worker must answer the child's questions truthfully and encourage the child to talk freely about death and dying. Sometimes the child's parents might avoid talking about death with the child because of the emotional content for all concerned. Avoiding direct discussion can reinforce the child's belief that the

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situation is too overwhelming to deal with (Lewandowski & Baranoski, 1994:520).

Eiser and Main (2000:12) argued that adjustment is not only affected by the characteristics of the illness, but that social and family variables also play a significant role.

2.3.5 Family variables

Family relationships play a very important role in determining the child's reaction and adjustment to hospitalisation or to unfamiliar situations. Cohesiveness and harmonious relationships within the family are strong protective factors for children, promoting their adaptation (Edwards & Davis, 1990:19). Several authors identified family communication as an important predictor of adjustment in hospitalised children (Eiser & Main, 2000; Baider *et al.,* 1996; Edwards & Davis, 1990).

Parents who engage in open communication within the family and allow their children the opportunity to express their feelings, are likely to affect the child's adaptation to hospital in a positive way. On the other hand a family with poor communication or which is dysfunctional might add more stress to the child in hospital and might have a negative impact on the child's adaptation. This child might also lack the skills and ability to cope in the hospital setting. Eiser and Main (2000:10) argued that the way in which parents convey information about the illness to the child is a significant predictor of distress in the child. Parents have to use simple and age-appropriate terms when talking to their children about their illness. They also have to pick an appropriate time for this discussion.

Chronic illness in children is a potential stressor for families. Some authors (Eiser & Main, 2000:10; Spirito *et al.*, 1994:315; LaGreca, 1990:287) agreed that stress is primarily responsible for increasing the risk of adjustment

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problems in chronically sick children. Parental coping and adaptation largely predict the child's adjustment to hospitalisation. Parental stress has the potential to increase the risk of adjustment and coping problems in the child if it is not properly addressed. Concurrent stressors on the child and the family may exhaust the family's normal coping mechanisms and further complicate the child's coping and adaptation to hospitalisation.

This crisis situation draws on all the family's resilience and coping mechanisms, which may well prove inadequate (Chandler *et al.*, 1990:152). The medical social worker acts as a catalyst for the patient's family to ensure that they will continue to provide ongoing emotional support during and after the child's hospitalisation (Berger, 1994:14).

2.3.6 The child's coping strategies

Social workers need to be aware of various coping strategies used by hospitalised children in dealing with their illness. The role of the social worker involves facilitating and promoting adaptive coping patterns in the patients and assisting them to adjust to a chronic or trauma-related illness. Gilbert (1999:280) divided coping strategies utilised by hospitalised children into three categories: affective, cognitive and problem focused coping.

2.3.6.1 Affective coping

Affective coping occurs when the child makes an effort to reduce anxiety or other stressful feelings associated with the illness (Gilbert, 1999:28). The reduction of anxiety is achieved by eliciting social support from family members and significant others. Social support from family members and friends plays a significant role in the adjustment of patients to their illness and hospitalisation (Baider *et al.*, 1996:94). Family members can provide reassurance and empathy and allow the child to voice his feelings about the illness. Affective coping is likely to be effective as it allows the child the opportunity to experience the anxiety and deal with it through the support of family and friends.

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2.3.6.2 Cognitive coping

Cognitive coping refers to the child's mental attempts to make sense of his illness by deliberately trying to alter his perceptions thereof (Gilbert, 1999:29). This coping strategy is also used to decrease anxiety and stressful feelings associated with the illness. Cognitive coping appears to be mostly focused on avoidance of the anxiety and is used when children do not have much control over the stressor. Children who use avoidance, block information about the stressor or behave in ways to avoid the stressor (Spirito *et al.*, 1994:314). Cognitive coping strategies seem to only offer a temporary relief from the stressor. Reference to cognitive coping Gilbert (1999:29) distinguished between spiritual, cognitive behavioural and perspective coping.

Spiritual coping occurs when the children use inner strengths and religious beliefs to help them cope with their illness. Children might experience less anxiety because of their belief that the illness is God's will and might find relief in prayer. Horn *et al.* (1995:124) acknowledged religious beliefs as a coping strategy used by the families and the child during hospitalisation.

Cognitive behavioural coping is a strategy employed to distract the child's attention from the illness. The child might decide to think about a pleasant experience, or might engage in physical activities in order to keep busy and avoid thinking about the illness.

Perspective coping refers to the use of humour or defence mechanisms to reconstruct the potential harm from the illness into something less threatening. For example, a child who sustained fractures and ended up with both legs in plaster may joke about having a year's supply of "ice cream" instead of thinking of the plaster as a physical restriction. The child may also focus on the fact that he will not have to do house chores, and avoid thinking about other limitations.

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2.3.6.3 Problem-focused coping

Gilbert (1999:30) described problem-focused coping as efforts done by hospitalised children, which are intended to reduce or eliminate the stressor. Problem-focused coping can also be divided into active, prevention and anticipatory coping.

Active coping involves actions to obtain relief from an existing illness. These actions may include taking medication to relieve pain or other symptoms associated with the illness. Active coping therefore promotes adherence to the prescribed treatment.

Children might also use *prevention coping* to prevent the onset of the illness-related pain. A child with diabetes may learn to avoid stimuli like sweets and fatty foods that may aggravate an increase in the blood sugar level and induce illness.

Hospitalised children may also use *anticipatory coping*, which involves advanced planning in anticipation of an illness. An example of anticipatory coping is when a child who was hospitalised following sexual assault by a stranger, learns to follow certain guidelines for his safety in future.

Social workers play an important role in helping the hospitalised child and the family cope with the illness. In planning intervention with a hospitalised child the social worker has to know which coping strategy is employed by the child. Research suggests that the use of active coping strategies, such as information seeking, minimise distress associated with medical procedures better than avoidant behaviours (Spirito *et al.*, 1994:314).

The role of the medical social worker is to provide emotional support for the child and family during the period of hospitalisation, serving as a link between the children's families and the health care professionals. Shields *et al.* (1995:50) and Horn *et al.* (1995:123) identified poor communication between

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the parents and the medical practitioners as an area needing careful consideration and social work involvement. In the role of mediator, the social worker might be able to strengthen the family's support system, which is essential to the child's recovery. The social worker has to ensure that the correct information about the child's illness is communicated in simple terms to the parents. Shields *et al.* (1995) suggested that the social worker should try to determine if parents are well informed about or at least understand their child's illness. Parents who are well informed could in turn explain the illness clearly to the child and so help him cope better with the illness and contribute to his adjustment to the hospital.

2.5 SUMMARY

Despite the improvements in the care of children in hospital, being admitted to a hospital still remains a potentially distressing experience for a child. It is important to know the stipulations of the South African legislation in relation to hospitalised children. The Child Care Act functions as a reference base for medical social workers, especially in terms of the advocacy and child protection roles within the hospital.

Children's experience of hospitalisation is determined by a number of factors that may in turn affect their adjustment. These factors include the child's intellectual capacity; physical restrictions caused by the illness; his understanding of the illness, and the characteristics thereof. Family variables also play a significant role in predicting the child's adaptation to hospitalisation. The parents' ability to cope with stress largely determines the child's reaction to the trauma induced by the illness. Stress has the potential to increase the risk of adjustment and coping problems in the child if it is not addressed properly.

Hospitalised children use affective, cognitive and problem-focused coping strategies to help them deal with the anxiety associated with the illness. Social

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support is of paramount importance in helping the child adapt to hospitalisation and to speed up recovery. Social workers, alongside the family, function as part of the child's support system.

The social worker needs to carefully assess and identify potential stressors within the child's family system, as they can negatively affect the child's functioning and ability to cope with hospitalisation. The role of the social worker involves facilitating and promoting adaptive coping patterns in the patients and helping them adjust to a chronic or trauma-related illness. These responsibilities together with an ever increasing work-load, could cause stress, which could adversely affect their work performance and job satisfaction. As they form part of the medical team, impaired work performance would also have a bearing on the child's response to medical care. The different factors contributing to burnout in social workers will receive further discussion in the following chapter.

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CHAPTER 3

SOCIAL WORK INTERVENTION WITH HOSPITALISED CHILDREN: FACTORS CONTRIBUTING TO BURNOUT IN SOCIAL WORKERS

3.1 INTRODUCTION

The main aim of the medical social worker is to help people facing illness, trauma-related crises or disability to understand and manage the psychosocial impact on their lives and on significant relationships, and to plan for the future (Ross, 1995:1369). When patients can cope constructively with these crises, the occurrence of further psychological and emotional problems is prevented (Funnel, Levin & Hochstadter, 1990:367). Social workers have to carefully select an appropriate practice frame of reference when dealing with hospitalised children. This requires a careful selection of the perspectives, theories and models to ensure effective intervention (Sheafor *et al.*, 2000:86). In most cases social workers do not focus on a single approach but make use of several theoretical frameworks, which give greater direction to the social worker's intervention.

Support from supervisors is essential. The social worker is assisted by the supervisor when taking difficult decisions, and this relieves possible feelings of guilt that might arise should the intervention not be successful (Botha, 2000:214). Support from supervisors also promotes motivation and job satisfaction.

Stressors often originate either within the person or from the outside environment, including both the occupational and non-work environment (Jones *et al.*, 1991:444). Some authors (Acker, 1999:116; Compton & Galaway, 1999:503) associate vulnerability to burnout with age and argue that younger social workers are more likely to experience burnout and might as a result leave

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their jobs. There are different types of stressors and the degrees to which they affect individual social workers differ. If these stressors are not properly dealt with they might lead to burnout amongst medical social workers, which will have a direct bearing on the child's benefit from medical services.

The practice framework of medical social workers working in children's wards will be discussed in the next section.

3.2 SOCIAL WORK PRACTICE FRAMEWORK

Social workers need to have a special understanding of and skills to deal with the psychosocial impact of illness, disability, hospitalisation and death (Funnel *et al.*, 1990:367). Social workers play an important part in total patient care and therefore need to make a careful selection of practice frameworks that are most suitable for use in working with hospitalised children. A practice framework consists of a set of beliefs and assumptions about how and under what conditions people change and what the social worker can do to facilitate desirable change (Sheafor *et al.*, 2000:82). Practice perspectives, theories and models provide structure and directives for social work intervention.

3.2.1 The general systems perspective

The general systems theory describes the principles underlying the functioning, growth, development and mutual interaction of systems (Sheafor *et al.*, 2000:89). Before the social worker can consider any therapy, it is important to assess the child fully within his family system (Scheepers, 1994:9). During the initial assessment the social worker's focus is on how the family system affects the child's ability to cope with hospitalisation. Within this family system there are smaller subsystems, which can be identified through the interaction among family members. These subsystems are the spouse subsystem (husband- wife relationship), the parental subsystem (parent-child relationship) and the sibling subsystem (child-child relationship). These are significant relationships which are disrupted when the child is hospitalised. Potgieter (1998:55) argued that

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when any one part of the system is changed, all other parts of that system are affected and change in some way. Scheepers (1994:9) summarised the general systems perspective as follows:

- The parts of the family are interrelated
- One part of the family cannot be understood in isolation from the rest of the system
- Family functioning as a whole cannot be fully understood by simply understanding each part of the family, and
- The family's structure and organisation are important factors determining the behaviour of family members.

The child's illness causes the roles of the family members to change and this might affect the family relationships and the overall functioning of the family. This is supported by Scheepers (1994:10) who also identified role change as one aspect of family functioning that influences a child's ability to handle emotional trauma. For example, a mother might have to spend long hours at the hospital with the ill child, leaving the siblings at home with the father who would have to attend to domestic duties. The absence of the mother might put strain on the family relationships and this could negatively affect both the spouse and the parental subsystem. How the family deals with the strain might facilitate or hinder the child's recovery (Ross, 1995:1368).

The role of the social worker often involves the assessment of family functioning and how it affects the child's ability to cope with illness. The social worker assists the family system to achieve homeostasis or equilibrium, which is a favourable and steady state of functioning (Sheafor *et al.*, 2000:90). There has to be a balance among the various parts of the system; this balance is not fixed or static, but is maintained ideally within a range of change that allows the system to function and maintain itself (Johnson, 1995:12). To this end, all parts of the system (family members) need to be constantly involved in making

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adjustments to their own individual functioning. The social worker needs to help the family identify areas that need adjustment in order to facilitate healthy functioning, which is essential for the child's adjustment to the hospital and recovery. Stable families that are able to effectively deal and cope with the child's illness are more likely to promote recovery in the child than are those with decreased levels of functioning. The social worker focuses on developing the interpersonal relationships within the child's family in order to promote healthy functioning of both the family members and the hospitalised child and to cultivate their strengths.

3.2.2 The strengths perspective

The social workers' focus is on the clients' strengths and capabilities rather than on their problems. Hepworth, Rooney and Larsen (1997:198) and Cowger (1994:264) argued that concentrating on deficits impairs the social worker's ability to discern clients' potential for growth and provides obstacles to clients' exercising of personal and social power. Positive and lasting change can be achieved by focusing and building on the clients' strengths. Saleeby (2000:13-17) identified five basic principles underlying the strengths perspective.

- *Every individual, group, family and community has strengths.*

The strengths perspective is based on the principle that every individual possesses strengths that must be identified and called into play by the social worker during intervention. The role of the social worker is to unleash the strengths within people and the strengths available to people in their own environment (Cowger, 1994:264). The social worker focuses on their capabilities to use their resources to overcome whatever crisis or stresses they may be experiencing. Making clients become aware of their strengths, tends to kindle their hopes and generate courage to make changes (Hepworth *et al.*, 1997:543). The social worker therefore, needs to identify the strengths carefully because they may be obscured by the stresses of the moment or submerged under the weight of the crisis or illness (Saleeby, 2000:14). In the case of hospitalised

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children the social worker focuses on their strongest characteristics and on what they can do despite their illness.

- *Trauma, abuse, illness and struggle may be injurious but may also be sources of challenge and opportunity.*

The social worker focuses on people's ability to survive through trauma, abuse, illness and struggle. Saleeby (2000:14) used the "challenge model" to explain how children who have experienced these crises can be perceived. These children are seen as active and developing individuals who, through these crises learn new skills and develop personal attributes that have a positive effect in their adulthood. In dealing with a hospitalised child the social worker would encourage the child to view the illness as a challenge and a learning experience that will promote growth within himself as well as to develop new skills of coping with a crisis. The child is regarded as a survivor rather than a victim. This would in turn decrease the child's negative attitude towards the illness and might facilitate recovery.

- *No one can know the upper limits of a client's capacity to grow and change and client's aspirations should be taken seriously.*

The social worker emphasises the client's healing and wholeness, which is the inborn facility of the body and mind to generate and resist when faced with illness or crisis (Saleeby, 2000:12). People's emotions are known to affect their health and the social worker needs to give pre-eminence to the client's understanding of the problem (Cowger, 1994:266). The social worker should focus on the client's view of the situation, the meaning he ascribes to it and the feelings related to that situation. By broadening their perspective of clients, social workers may enhance the efficacy of their intervention efforts (Hepworth *et al.*, 1997:198). The social worker should acknowledge the child's interpretation and feelings about the illness. However, the social worker also needs to help the child focus on the facts of the illness. A typical example is that of children living with HIV/AIDS whose immune system is compromised by

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the virus. High levels of stress in these children increase the rate of deterioration of the immune system. The social worker, through the strengths perspective, could reaffirm their hopes of living a long normal life, with the virus, but also ensure that they understand that the virus is not curable. When they believe that they can sufficiently alleviate the symptoms of the illness, chances are that their bodies will respond positively to treatment, which in turn will improve their general well-being.

- *Clients are served best by collaborating with them.*

Clients, not social workers, own the power that brings significant change to their lives (Cowger, 1994:265). The social worker needs to move away from the role of expert to a collaborative role that includes the patients in decision-making about their treatment. Hepworth *et al.* (1997:198) and Cowger (1994:266) supported this view and argued that social workers need to achieve a more balanced perception of their clients and to minimise the power imbalance inherent between them and clients, by allowing clients to experience ownership of the intervention process. In this way, the social workers reinforce competence and collaborate with the clients. This collaboration might promote resilience in an ill child, and build the child's self-esteem and self-confidence. The result might be a positive attitude, which would in turn promote maximum benefit from treatment

- *The environment, in which the client lives and functions, is full of resources.*

In his collaboration with the client, the social worker also investigates the resources within the patient's environment, which include family, friends and community organisations. According to Saleeby (2000:16) these resources may offer something to the child, which could be essential in reinforcing healing and recovery. The social worker must help the child identify potential helping resources within his own environment as strengths also exist in this surrounding network (Johnson, 1995:145). For example, a sibling might help to relay messages to the patient's friends and provide feedback to the patient,

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thus helping the child to remain in touch with the outside world. Cowger (1994:263) emphasised the importance of social empowerment of the client, which refers to recognition of the client's influence and role in his environment. The assumption is that resources and opportunity for empowerment are available in the client's environment.

The medical social worker uses the strengths perspective to promote resilience in hospitalised children, and build their self-esteem and self-confidence in order to promote positive recovery from illness. The social worker puts emphasis on the positive aspects within the child's environment, systems and resources. Resilient children have a positive attitude towards life and challenges, which could in turn reinforce effective functioning in adverse situations. On the other hand, children who have adaptation problems will make more demands and are likely to increase the stress levels of the social worker.

Both the general systems and strengths perspectives are used in conjunction with relevant theories and models, determined by the type of clients dealt with and specific problems.

3.2.3 Practice theories

Through personal experience of working in a hospital the researcher has observed that most children who are hospitalised for long periods of time exhibit behaviour problems. These behaviours usually interfere with the child's treatment process and to a large extent, his recovery. The social worker needs to firstly specify and operationally define behaviour(s) that need either to increase or decrease in frequency, duration or intensity (Sheafor *et al.*, 2000:98). By use of the *behaviour theory* the social worker can facilitate change by helping the child eliminate dysfunctional behaviours and learn desirable patterns of functioning. The social worker needs to ensure desirable behaviour is rewarded instead of undesirable behaviour. For example, a child who refuses

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to take medication should not be permitted to get out of bed until such time that he takes the medication. He should be praised when he does so.

At times the social worker needs to change the child's way of thinking before attempting to change the actual behaviour. This can be done using of *cognitive behavioural theory.* The social worker assists the client to learn more realistic and positive ways of perceiving, thinking about and interpreting his or her life experiences (Sheafor *et al.*, 2000:99). This theory however, might not be applicable to children in the early childhood stage due to their limited cognitive capabilities. The cognitive behavioural theory is likely to be applied when working with children in the middle childhood stage as their cognitive skills have already developed. This theory can also be used with the parents of hospitalised children as the social worker often involves them during intervention. The social worker helps the child to identify, monitor, re-examine and correct patterns of thought and faulty assumptions that give rise to problems (Sheafor *et al.*, 2000:99). For example, a child who has been diagnosed with HIV might be depressed and suicidal because of limited information about HIV. The role of the social worker would be to educate the child about the illness, to help him or her unlearn the stereotypes and stigma associated with it. When the social worker is confident that the thoughts about addressing the illness are constructive, focus can be shifted to modifying the undesirable behaviour.

During intervention the social worker utilises specific models incorporating these theories.

3.2.4 Practice model

The model most often used by medical social workers is the *crisis intervention model* as illness and hospitalisation are usually sudden and unexpected events that affect the child's level of functioning. When people face a crisis, they cope in either an adaptive or a maladaptive way (Hepworth *et al.,* 1997:391). Use of

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this model is usually restricted by time and the social worker aims to help the client return to a state of equilibrium and his normal level of functioning. Hepworth *et al.* (1997:391) identified three objectives of crisis intervention, namely to relieve the client's emotional distress, complete an assessment and plan a strategy of intervention.

The social worker attempts to relieve the client's emotional distress by providing emotional support. The child is encouraged to talk about the feelings associated with the illness, and the social worker replies with the correct, empathetic response (Hepworth *et al.*, 1997:391). Social support from family, friends and significant others, might also reduce emotional distress induced by the illness, and could facilitate the child's recovery.

Assessment is an important facet of crisis intervention, especially in the beginning stages of the intervention process. Assessment is described as a democratic and interactive process in which the social worker, patient and family identify significant psychological factors, social relationships and environmental issues to be addressed within the context of the particular medical circumstances (Ross, 1995:1371). The social worker is required to determine the nature of the crisis, its significance to and impact on the client, factors that precipitated the crisis, adaptive capacities of the client and resources that can be used to alleviate the crisis situation (Hepworth *et al.*, 1997:392). Assessment therefore provides the social worker with an understanding of what the crisis means to the child and also helps the social worker identify intervention strategies.

Working in crisis situations can be potentially stressful for medical social workers, as they have to assess, plan and provide a strategy within a limited time. The time available might not be enough for the child to recover fully from the imbalance caused by the crisis. Furthermore, social work intervention might at times be inadequate to help the child overcome distress and the strong

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emotions associated with the crisis. Social workers therefore, have to ensure that they choose the best and most appropriate intervention strategies to deal with problems experienced by hospitalised children.

These theoretical frameworks provide structure and directive to social work intervention and combined with supervision would promote job satisfaction amongst medical social workers.

3.3 MEDICAL SOCIAL WORK

The persistent association of social work with health care issues can be attributed to the fact that many health problems are inseparably linked to social factors (Ross, 1995:1366). It is very important that all the health care professionals involved, work together to help the parents understand and cope with the child's illness. The social worker is the facilitator in this process. Working in a hospital, the social worker needs to function as part of a multi-disciplinary team in dealing with issues related to children's illnesses.

3.3.1 Multi-disciplinary teamwork

As a member of a multi-disciplinary team, the medical social worker provides insight into and understanding of the psychosocial dimensions of the medical circumstances affecting particular patients and families (Ross, 1995:1369). Trends in social problems and professional practice make it virtually impossible to serve clients effectively without collaborating with professionals from various disciplines (Bronstein, 2003:297). Medical social workers engage in interdisciplinary collaboration in dealing with patients' problems, which refers to an effective interpersonal process facilitating the achievement of goals which cannot be reached when individual professionals act on their own (Bronstein, 2003:299). Each member of the multi-disciplinary team has a unique but significant role to play in the care of hospitalised children.

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The roles of these members are interdependent despite the differences that exist among the disciplines. Interdependence refers to the occurrence of and reliance on interactions among professionals whereby each is dependent on the other to accomplish his or her goals and tasks (Bronstein, 2003:299). For example, a social worker dealing with a suspected child abuse case might not be able to remove a child from the parents' care unless medical findings confirm the abuse. At the same time a doctor might not be able to discharge a child into the care of the parents if there is suspicion of abuse until the social worker has made an assessment of the home circumstances to establish risk factors.

Members of the multi-disciplinary team work together closely to find solutions to the patient's problems. Social workers co-ordinate and help to implement team decisions, provide consultation, and advise and counsel colleagues based on their knowledge of human behaviour (Ross, 1995:1373). An advantage of teamwork is the merging of expertise and knowledge from different disciplines, which maximises creativity within today's complex problems (Bronstein, 2003:300).

It is generally accepted that the medical social worker is an important link in the medical multi-disciplinary team (Berger, 1994:14). Within the team, it is the social worker that has a broad view of patients in their social environment and an awareness of both potential supports and gaps in service in the community (Herbert & Levin, 1996:73). The medical social worker plays an advocacy role within the multi-disciplinary team, which involves liasing between the patient and the multi-disciplinary team. The medical social worker is in a unique position to advocate for the clients within their system and within the community on behalf of the clients (Herbert & Levin, 1996:82). Sometimes there may be differences of opinion between the members of the multi-disciplinary team due to their lack of understanding of the clients within their social environment, which could in turn put pressure on the medical social worker. This places a huge responsibility on the social worker, which can be very

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rewarding but if not supported by other team members can lead to stress and burnout.

Medical social workers need to have social support from colleagues and supervisors to ensure that decisions taken within the team are appropriate. Support can be strengthened through supervision, which is discussed in the following section.

3.3.2 Supervision

The nature of the work of medical social workers is potentially stressful and can be hazardous to their mental health. Supervision makes an essential contribution to social support of social workers as it can help alleviate job-related stress and promote job satisfaction. Supervisors are vital in helping social workers learn new skills, evaluate the effectiveness of their work, develop competence in their work and understand the purpose and function of the agency (Compton & Galaway, 1999:504). Before supervision of the social worker can take place, it is essential that a positive climate and work environment be established (Botha, 2000:211). The environment in which the social worker is to be supervised, should be warm and unthreatening. This could motivate the social worker to develop a desire to learn and be productive. Botha (2000:212) identified the following activities that supervisors should perform to enhance support:

- Set an example through conduct on how social workers should act towards and negotiate with clients.
- Assist young and inexperienced social workers with difficulties they might experience in service rendering. The supervisor should however also allow the social workers an opportunity to learn.
- Teach social workers how to handle stressful situations.

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- Show interest in the social workers' progress by regularly praising progress achieved. Social workers should also be encouraged when they are feeling despondent about their work.
- Always provide feedback in a positive and constructive manner. Feedback is very important because the social workers should be able to identify areas of work that need development. Feedback also helps the social workers acquire skills to use in the future should similar problems arise.
- Assist the social workers with administrative tasks by explaining their meaning, importance and relevance to the job.
- Encourage redesigning of the social workers' job within the organisation in order to reduce stress associated with role conflict, financial rewards, working conditions and promotion opportunities. The supervisor could advocate on behalf of the social workers by acting as a link between them and management. The supervisor should also keep the social workers updated with new developments in the field of social work.

In fulfilling a supportive role the supervisor ensures that the workers execute their duties correctly. The supervisor could also assist social workers in decision-making in difficult cases. This would lessen any feelings of guilt should the result not be satisfactory (Botha, 2000:214). The role of the supervisor is not to do the social workers' job but to assist and guide them so that they can be confident in their work. Supervision is a two-way process that requires input from both the social worker and the supervisor. A social worker that receives supportive supervision is likely to feel motivated, dedicated and empowered to do his or her work to the best of his ability. This dedication would increase the level of job satisfaction and hence the level of productivity.

Conversely, social workers that do not receive supportive supervision are likely to experience decreased levels of motivation and less enthusiasm about their

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work and this might eventually lead to burnout. The factors that contribute to burnout are discussed in the next section.

3.4 FACTORS THAT CONTRIBUTE TO BURNOUT IN MEDICAL SOCIAL WORKERS

Burnout is a term that has been widely used (Compton & Galaway, 1999; Sheafor *et al.*, 1997; Collings & Murray, 1996; Kadushin, 1992;Gibson *et al.*, 1989) to describe different aspects of job related stress. It refers to a state of mind that frequently affects individuals working with other people and who perceive themselves as contributing much more than what they receive from their clients, supervisors and colleagues (Gibson *et al.*, 1989:2). Burnout is a serious form of stress that can severely impair the worker's effectiveness.

Workers in the care-giving professions, including social workers, have frequently been reported to be prone to burnout (Compton & Galaway, 1999; Collings & Murray, 1996; Ross & Altmaier, 1994; Siefert *et al.,* 1991). This is partly due to the nature of the work that social workers do and is particularly relevant in social work intervention with hospitalised children. Because social work is client-centred, and requires emotional involvement, which puts stress on service providers, it is not uncommon to have emotionally drained and chronically frustrated workers (Acker, 1999:113). Burnout has negative consequences for the individual social worker, the organisation and for clients. Social workers suffering from burnout usually develop negative self-concepts, negative job attitudes and reduced concern for clients. These workers experience a decreased level of motivation and less enthusiasm about the job, which in turn contribute to poor job performance.

Potter (1994:6) described burnout as a cumulative process, beginning with small warning signals that, when unheeded, can progress into a profound and lasting dread of going to work. The social worker initially experiences stress, which eventually develops into burnout if it is not properly dealt with. There are

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various signs and symptoms that are indicative of burnout and these may be identified in the individual social worker, the helping relationship and work environment (Compton & Galaway, 1999:502). Burnout is usually characterised by emotional, mental and physical exhaustion.

3.4.1 Emotional exhaustion

Burnout victims constantly experience *negative emotions* such as frustration, anger, depression, dissatisfaction and anxiety until these emotions become chronic (Potter, 1998:6). The social worker may blame himself for shortcomings related to the job and might end up dissatisfied and depressed and this can lead to a decreased level of job performance. The consequences of burnout can negatively affect the worker's effectiveness and service delivery. Compton and Galaway (1999:502) argued that burnout is also costly for an organisation as it often has to carry inefficient workers. Most of the time the person is frustrated in his job and regards it as hopeless and meaningless, which may result in feelings of helplessness. An example is when medical social workers are involved in psychosocial assessments of children that require organ transplants. A number of eligible children are often identified but due to a lack of donors many patients die while awaiting transplants. This situation might evoke feelings of helplessness, depression and lack of control in the social workers. The social workers' level of motivation and enthusiasm might decrease.

Interpersonal relationships of the medical social worker are also affected by consistently negative emotions. The burnout sufferer tends to overreact with emotional outbursts or intense hostility towards other people when small conflicts arise (Potter:1998:9). People suffering from burnout tend to distance themselves emotionally from social interactions, especially if they find the situation difficult to deal with. Such negative attitudes and emotional outbursts affect both private and work relationships, alienating the person from colleagues, family and friends. Alienation from significant others might deprive

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the burnout victim of social support which is very often needed by medical social workers.

The social workers might also develop personal problems such as *substance abuse,* as occupational stress becomes chronic. They may seek chemical solutions to help them deal with overwhelming emotional demands and stress they experience due to an inability to cope (Potter, 1998:12). Substance abuse can be anything from excessive intake of alcohol and drugs to increased intake of food. Because the substance cannot remove the underlying causes of the problems the social worker might end up taking more of the substance and therefore increasing the risk of addiction.

3.4.2 Mental exhaustion

A mentally exhausted person usually has negative attitudes towards work, clients and colleagues, which are reflected through *dehumanisation.* Ross and Altmaier (1994:14) and Potter (1998:10) identified dehumanisation as a form of emotional withdrawal, which is usually displayed by the burned-out worker as a failure to respond to the feelings and problems of other people. Acker (1999:112) and Compton and Galaway (1999:502) also used the term depersonalisation to describe the social worker's attitude. As a result, clients are seen as objects rather than people and social workers might find it difficult to respond empathetically to the clients' problems. Medical social workers are a potentially at risk of developing emotional withdrawal due to job-related stressors. This might be evident in situations where medical social workers deal with very ill children over long periods of time. At times these children develop behaviour problems, which adds strain and pressure on the social worker who is trying to help them. Under these circumstances, the social worker is likely to display growing dehumanisation, especially if the child's behaviour does not change. The social worker might become intolerant, impatient and react with hostility towards the child, who is regarded as hopeless and incorrigible. A

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further danger of dehumanisation is that these attitudes can be projected onto the social workers' private relationships.

As emotional and mental exhaustion increases, the social worker's physical resilience declines, which contributes to physical exhaustion.

3.4.3 Physical exhaustion

The symptoms of physical exhaustion due to burnout include chronic fatigue, low energy levels and weakness (Ross & Altmaier, 1994:14). Social workers who suffer from burnout usually experience *health problems* and minor illnesses become more frequent. The most commonly experienced illnesses are backaches, colds, headaches, hypertension, insomnia and ulcers (Potter, 1998; Compton & Galaway, 1999; Ross & Altmaier, 1994;). Frequent illness can contribute to poor job performance and it therefore becomes a vicious cycle.

The health problems are likely to create a pattern of absenteeism among the affected social workers, which can indirectly cause problems in productivity and job performance. Within the health care profession, burnout results in inefficient workers, low morale, absenteeism and high turnover while some social workers may even leave their jobs (Acker, 1999; Compton & Galaway, 1999). These problems not only affect the profession but they also affect service delivery to clients. This in turn prevents children from receiving maximum benefit from medical services. Children who do not receive social support from social workers might experience problems in adapting to the hospital, which could hinder the process of recovery.

Apart from personal experiences, job-related stressors can also influence job satisfaction in a negative way and in turn increase the likelihood of burnout.

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3.4.4 Job related stressors

Several studies (Bennet *et al.*, 1993; Siefert *et al.*, 1991) found social workers employed in child care services and health care services to have significantly high levels of stress. The nature of the work that medical social workers do with regard to hospitalised children is potentially stressful. It is a very demanding job, and requires the social worker's commitment to and understanding of children of different age groups. The social worker is often the child's only source of support in the hospital when the family is not around. Their demands put increasing pressure on the social worker who might already be overwhelmed by other work-related stressors. In an attempt to address the demands, the social worker could lose focus, and begin to harbour negative feelings or attitudes about the work and clients. These negative emotions are risk factors of burnout.

However, in various studies (Potter, 1998; Collings & Murray, 1996; Jones *et al.*, 1991; Siefert *et al.*, 1991 Gibson *et al.*, 1989) different job related stressors, which promote burnout were identified. The most commonly identified stressors relate to job constraints, role conflict and role ambiguity, work overload and organisational structures.

3.4.4.1 Job constraints

Job constraints refer to the degree to which the environment confines or prevents a worker from surviving or coping with the demands made upon him (Jones *et al.*, 1991:445). Constraints within the person's work environment can play a significant role in his general level of job performance. Lack of recognition of the social worker's efforts and capabilities forms part of job constraints, as it can erode enthusiasm for working and to some degree contribute to burnout (Potter, 1998:36). Lack of recognition of the social worker's efforts and capabilities can be reflected through remuneration, lack of support from superiors or supervisors and the social worker's position within the organisation.

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Inadequate remuneration has often been identified as a problem in the social work profession adding to reduced job satisfaction (Potter, 1998; Collings & Murray, 1996; Siefert *et al.*, 1991). Social workers usually feel that their efforts and outputs are not adequately recognised financially. A burned out worker may feel that he/she is putting much effort into the job but is receiving inadequate pay for the hard work he/she does. Through personal experience and discusson with other social workers employed by the Department of Health, the researcher has observed that medical social workers often complain of inadequate remuneration caused by constant budget cuts by the Department of Health. The Department of Health is concerned with saving costs, which includes putting on hold promotion of employees and introducing new merit systems that can only be accessed by one per cent of employees in each department. For the past two years this promotion system has not been implemented, which means that the social workers' chances of financial rewards are very small. This situation might cause medical social workers to feel stuck in a hopeless situation. The chances of burnout therefore increase.

Lack of support from superiors is a very important factor that has been identified as a significant source of stress among medical social workers (Collings & Murray, 1996 & Jones *et al.*, 1991). The relationship between the social worker and co-workers or supervisors may also cause additional stress if they are in competition or in conflict with one another (Compton & Galaway, 1999:504). Superiors who constantly criticise their workers might precipitate burnout among these workers. Excessive criticism of everything that a social worker does might contribute to feelings of powerlessness. The social worker might lose motivation and enthusiasm, which could be detrimental to job performance and productivity.

At times medical social workers feel that they are employed below their appropriate level of qualification. A significant number (52%) of social workers

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in the study conducted by Gibson *et al.* (1989:8) felt that the job did not always fully utilise their training and experience. Social workers often find themselves doing jobs they were not trained for and this might contribute to role conflict and role ambiguity.

3.4.4.2 Role conflict and role ambiguity

Very often medical social workers encounter barriers within the multi-disciplinary team that hinder their intervention. Role conflict and role ambiguity have been identified in a number of studies (Jones *et al.*, 1991; Siefert *et al.,* 1991) as some of the sources of stress leading to burnout if not properly addressed. Role ambiguity refers to a lack of clarity regarding a worker's rights, responsibilities, methods, goals and status within an organisation (Compton & Galaway, 1999:504).

The role of the medical social worker needs to be clearly defined, especially within a team of professionals from different disciplines, in order to avoid role ambiguity. Role ambiguity results from lack of information about the social worker's job and how he is expected to carry it out, which might cause confusion regarding job responsibilities. The social worker needs to have a clear job description in order to keep track of work done and to ensure that he is doing it in the correct and appropriate way. The likelihood of role conflict increases if the social worker's job description is unclear.

Other professionals within the multi-disciplinary team might have unrealistic expectations about the role of the social worker and these expectations might be in conflict with those of the social worker. Differences of opinion and disagreements often occur in multi-disciplinary teams. Owing to the fact that the different professions approach the client system from divergent perspectives, it is not always possible to find an acceptable compromise, which could result in complications and tension (Botha, 2000:201). These differences

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might give rise to frustration, anger and dissatisfaction, increasing the risk of burnout among social workers.

3.4.4.3 Work overload

Work overload has been frequently identified as a significant predictor of stress and burnout among medical social workers (Collings & Murray, 1996; Davies, 1998; Gibson *et al.*, 1989; Jones *et al.*, 1991; Potter, 1998; Siefert *et al.*, 1991). The social workers might experience difficulty in meeting deadlines due to work overload. On the other hand, the critical factor is not the actual size of the work-load, but the worker's perception of the work-load being too large (Compton & Galaway, 1999:504).

Social workers might also find it difficult if not impossible to plan ahead because of the nature of their work, which usually involves crisis intervention requiring immediate attention. Due to time constraints of crisis intervention, they might not be able to do in-depth intervention with the children. All public hospitals have emergency and outpatient departments where clients are admitted without prior arrangements and the daily influx of patients into these departments this could increase the work-load of social workers, causing more pressure.

The other factor that might contribute to work overload among medical social workers is a shortage of personnel. Compton and Galaway (1999:505) are of the opinion that while staff numbers might be reduced, the work-load seldom is, and social workers must contend with increased and often inappropriately large case loads. In the past decade the Department of Health reduced the number of social workers in each hospital by keeping the social work posts vacant when social workers resigned or retired. Under these circumstances work overload is likely to increase the social workers' anxiety and feelings of helplessness, which will increase the likelihood of burnout.

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3.4.4.4 Organisational structure

The organisational structure plays an important role in exacerbating the effects of burnout among medical social workers. The hierarchical structures within the hospital do not allow social workers an opportunity to have a say in the running of the organisation. Potter (1998:53) and Gibson *et al.* (1989:8) agreed that the hierarchical, bureaucratic organisational structures tend to undermine the autonomy of the social workers and minimise their personal power.

Hospitals impose rules and policies according to which social workers are expected to work and these are often not properly explained to them. Compton and Galaway (1999:504) and Jones *et al.* (1991:455) identified lack of clarity of the organisational goals, policies and procedures as factors contributing to low morale and frustration among social workers when trying to meet the demands of the job. This might contribute to difficulties in measuring the effectiveness of social work interventions.

All the abovementioned stressors promote the development of burnout among social workers in hospitals. The affected social workers experience feelings of powerlessness, hopelessness and anxiety, which could in turn decrease levels of motivation and enthusiasm, leading to burnout and poor work performance.

3.5 SUMMARY

Medical social workers utilise a number of intervention strategies to help patients deal with problems associated with their illness. Social workers have to carefully select a practice frame of reference that is appropriate for the type of client and problems dealt with. This frame of reference consists of perspectives, theories and models that the social workers employ to facilitate desirable change in the clients social system. The general systems perspective is used to understand how the family system impacts on the child's behaviour, functioning and ability to adapt to the illness and hospitalisation. Medical social workers use the general systems perspective to facilitate positive

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functioning within the family system and to strengthen the child's support system, which is essential for recovery. The strengths perspective is also used to empower children by promoting resilience and building self-esteem and self-confidence in order to promote positive recovery from illness. The perspectives are used in conjunction with various theories and models of social work intervention.

The most common theories that guide the medical social workers' intervention with hospitalised children are the behavioural and the cognitive behavioural theories. These theories help to eliminate problematic ways of thinking and behaviours that are acted out by the child, and which might hinder the process of recovery. The social worker assists clients to learn realistic and acceptable ways of thinking and behaving that will facilitate recovery. The crisis intervention model is often used by social workers working in a hospital setting. This model helps the child return to a normal level of functioning that was disrupted by the onset of a crisis (which is illness in this context). By means of the crisis intervention model the social worker assesses the effect of the crisis on the child, availability of social support and the child's coping capacities.

These theoretical frameworks provide a frame of reference, structure and direction for social workers in rendering intervention to children in hospital. At times medical social workers form part of multi-disciplinary teams, where patients' problems in relation to their illness are discussed. Social workers need social support from colleagues and supervisors, to ensure consistency and efficiency. Supportive supervision promotes motivation and dedication amongst social workers, which increases the levels of job satisfaction. Social workers who do not receive the necessary supervision might eventually suffer from burnout.

Burnout has been identified as a serious form of stress that can impair the medical social worker's effectiveness. It is characterised by emotional, mental

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and physical exhaustion. Working with hospitalised children often puts demands on the medical social worker because of the intense nature of the work. If the social worker cannot cope with the demands, he might experience negative emotions towards the job and the clients, which may lead to burnout. A burned out worker usually has feelings of negativity, powerlessness and hopelessness. This results in decreased levels of motivation and enthusiasm about the job that often lead to poor job performance.

The next chapter will therefore focus on an empirical study, which will investigate burnout amongst medical social workers working in children's wards.

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CHAPTER 4

AN INVESTIGATION OF BURNOUT AMONGST MEDICAL SOCIAL WORKERS

4.1 INTRODUCTION

Medical social workers working in children's wards encounter a number of stressors within their work, which make them vulnerable to burnout. Social workers need to be able to identify potential stressors and find effective ways to deal with them, in order to reduce the likelihood of burnout. Various authors (Compton & Galaway, 1999; Collings & Murray, 1996; Ross & Altmaier, 1994; Siefert *et al.,* 1991) reported social workers to be amongst professionals with an increased risk of burnout brought about by the stressful nature of their work. Chronically ill children often exhibit behavioural and emotional problems, which in turn put pressure on the social worker. Because social work requires emotional involvement, it is not uncommon for workers to be emotionally drained and frustrated, which is characteristic of burnout (Acker, 1999:113).

The main aim of this study is to provide guidelines for handling stress amongst medical social workers working in children's wards in order to prevent burnout and to promote job satisfaction.

4.2 EMPIRICAL STUDY

The following section contains the findings of the empirical research, which investigated factors contributing to burnout amongst medical social workers.

4.2.1 Sampling

The sample for this study consisted of ten medical social workers (N=10). The sample was selected using a purposive sampling method, which is based on the researcher's own knowledge of the population, its elements and the nature of the research aims (Rubin & Babbie, 1993:255). All of the respondents were

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medical social workers from hospitals in the Cape Metropolitan area, specifically those working in children's wards. The reason for this demarcation was that these hospitals function as major referral facilities serving the Cape Town city bowl, the southern suburbs and the Cape Flats.

4.2.2 Research method

To gather the data the researcher made use of questionnaires (Appendix 1), which consisted of both open-ended and closed-ended questions. The researcher approached the supervisors and heads of the social work departments in the respective hospitals, who gave permission for the social workers to participate in the study. The relevant social workers were approached personally and were handed or e-mailed questionnaires. Appointments were made to collect them. The response rate was therefore raised because of the personal contact involved and the fact that the researcher respected the respondents' work schedules (De Vos, 2001:155). The questionnaires sent by electronic mail did not increase costs and extended the geographical area covered by the researcher (De Vos, 2001:153). Confidentiality and anonymity of the respondents were emphasised by the researcher in the questionnaire in order to lessen resistance to participation in the study (Rubin & Babbie, 1993:317).

4.2.3 Demographic factors relating to the respondents

The respondents were asked to indicate their age, gender, marital status, academic qualifications, period of service in the hospital, years of service as social workers and their rank (level of employment). Some of these aspects will be discussed separately in the next section.

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4.2.3.1 Age

The respondents were classified into seven age groups. The age distribution is reflected in the following graph:

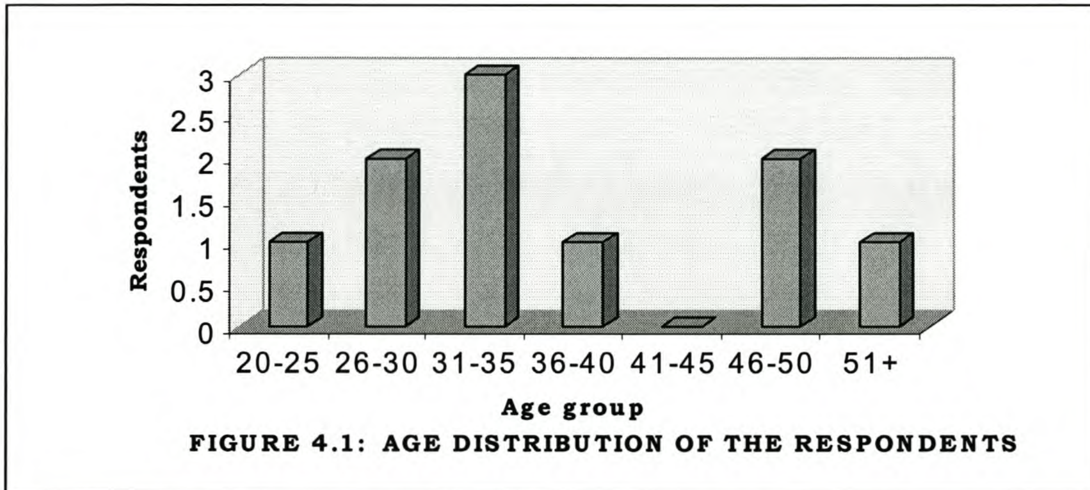

FIGURE 4.1: AGE DISTRIBUTION OF THE RESPONDENTS

(N=10)

Figure 4.1 shows that the largest group, 3 (30%) of respondents were between 31 and 35 years of age. Two respondents were between 26 and 30 years, while one respondent was in the 20 to 25 years age group. These findings show that the majority of respondents were young social workers, which increased the likelihood of burnout amongst them. These findings corresponded with those of Compton and Galaway (1999:503) pointing to vulnerability to burnout as being age-related, which means that younger social workers are more prone to burnout.

4.2.3.2 Gender

The respondents were requested to indicate their gender. There was only one (10%) male amongst nine (90%) female social workers, as reflected in Table 4.1.

Table 4.1: Gender distribution of the respondents

GENDER	F	%
Male	1	10
Female	9	90
Total	10	100

(N=10)

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The imbalance in the gender distribution can be ascribed to the fact that the social work profession is traditionally female dominated. The gender distribution did not seem to have any significant bearing on the results when considering how burnout was experienced by medical social workers. This supports the argument by Compton and Galaway (1999:503) that men and women generally experienced burnout in a similar fashion.

4.2.3.3 Work experience of the social workers

The period of service in the hospital was investigated in order to determine whether prolonged work experience of the social workers caused resilience to burnout. The period of service in the hospital reported by the respondents ranged from less than a year to 28 years. Three (30%) respondents had been working in the hospital for less than a year and one (10%) respondent had worked for less than five years. This implies that four social workers had been working in the hospitals for less than five years. These social workers were all under the age of 35 years. A possible explanation is that there had been a constant turnover of social workers in the hospitals within the last five years.

The remaining respondents were social workers above the age of 35 and had been working in the hospital for a period of between six to 28 years, with a work experience of eight to 35 years. The findings indicated that the younger social workers had changed jobs at least within the past five years. These findings were consistent with those of Acker (1999:116) who stated that younger social workers were less likely to remain in the same job than the older social workers were. Ross (1996:76) also found a steady decrease in the number of social workers who remained in the profession for any length of time, which in turn represented a loss in manpower, skills and experience. The present findings also indicated that those social workers who had been working in the hospital for a longer period had of course more work experience than the younger social workers. Due to their prolonged exposure to work-related stressors, it is possible that experienced social workers have overcome the

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worst effects of burnout and have developed effective coping mechanisms (Acker, 1999:117). The implication is that the older and more experienced a social worker is, the lesser the chances of burnout.

4.2.3.4 Ranks of the social workers

The respondents were also asked to indicate their rank, which refers to the position held in their work. The findings are reflected in Table 4.2.

Table 4.2: Years of service as a social worker

YEARS OF SERVICE	RANK/ JOB POSITION			TOTAL
	Social worker	Senior s/worker	Chief s/worker	
< 5years	3	1		4
6-10 years			2	2
11-15 years			1	1
16-20 years			1	1
21-25 years				
26-30 years			1	1
31-35 years			1	1
TOTAL	3	1	6	10

(N=10)

Table 4.2 shows that three (30%) of the respondents held positions of social workers in the hospital, which are the most junior ranks. These social workers all had less than five years' work experience. One respondent who also had less than five years work experience held the position of senior social worker. The remaining six (60%) of the respondents were all chief social workers and had work experience between six and 35 years. The findings reflected the fact that there are only two levels of promotion for the medical social workers. The most senior position is that of chief social worker and is the same for all the more experienced social workers regardless of the years of service. It seems that promotional opportunities for the social workers are very limited once they reach the top position. Potter (1998:36) identified limited promotional

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opportunities as a lack of recognition of the social worker's input and efforts, which can negatively affect that person's enthusiasm.

4.2.4 Case load of the medical social workers

High levels of stress have been significantly associated with high work-loads (Collings & Murray, 1996:383). In order to establish to what extent their work-load affected job satisfaction, the case loads were investigated.

4.2.4.1 *Total* case load

The respondents were asked to indicate the number of cases for the month of September 2003, including cases dealing with both children and adults. To ensure a realistic, relevant result, a distinction was made between total work-load and the number of children dealt with. The case load of the respondents is reflected in the following figure.

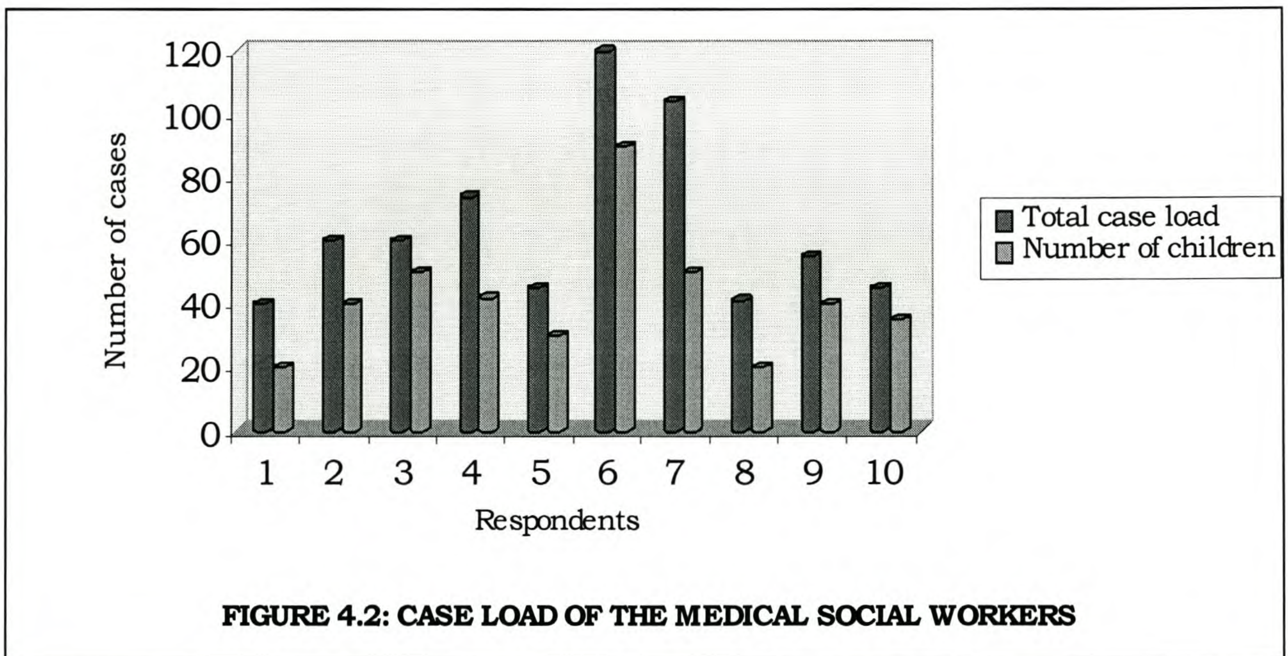

FIGURE 4.2: CASE LOAD OF THE MEDICAL SOCIAL WORKERS

(N=10)

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As can be seen in Figure 4.2, the total case loads of the individual medical social workers ranged from 40 to 120 cases. The findings showed that the medical social workers faced large case loads that they had to attend to on a regular basis. These findings correspond with those reported in various studies (Davies, 1998; Potter, 1998; Collings & Murray, 1996; Jones *et al.,* 1991; Siefert *et al.,* 1991; Gibson *et al.,* 1989;), which identified work-load as a significant predictor of stress and burnout amongst medical social workers. The type of cases that social workers deal with require in depth intervention due to the emotional content involved, which naturally takes up a considerable amount of time. Increased work-loads are potential stressors for medical social workers as they limit the time available for in-depth intervention, which in turn negatively affects the quality of service.

The number of children dealt with by the medical social workers ranged from 20 to 90 children per month. This meant that more than 50 per cent of each social worker's cases concerned children.

4.2.4.2 Demographics of the hospitalised children

As discussed in Chapter 2, children differ according to age in their understanding of illness and their reaction to the experience of hospitalisation. The ages of the children that were part of the respondents' case load are indicated in Figure 4.3.

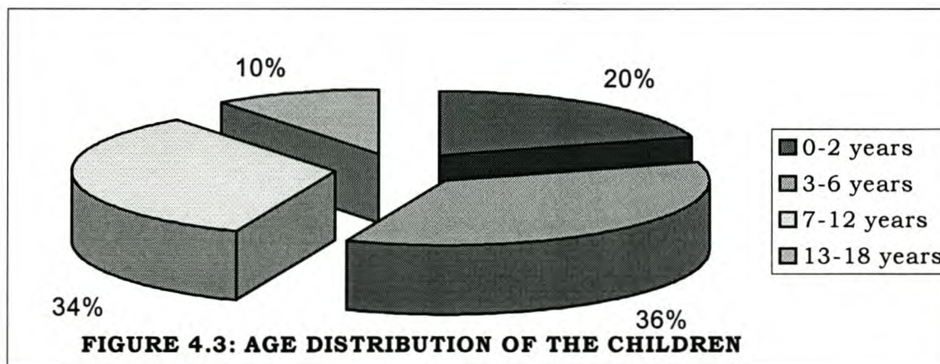

FIGURE 4.3: AGE DISTRIBUTION OF THE CHILDREN

(N=10)

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Figure 4.3 shows that the largest age group (36%) dealt with by the medical social workers consisted of three to six-year-old children. These children required specific social work intervention, as Sheafor *et al.* (1994:418) found their thinking to be egocentric and subjective, which in turn limits their understanding of their illness. Berger (1994:14) warned that the social worker has to explain the illness to the children to help them understand its implications and possible consequences. Figure 4.3 indicates that infants (0-2 years) constituted 20 per cent of the cases of children dealt with. These findings are in apparent contradiction with an assumption made by the author in Chapter 2 that medical social workers would not deal with infants (0-2 years). However, this could also imply that they do deal with cases involving infants, but the actual intervention would be with the parents or on a basic level with the child.

4.2.4.3 Type of cases dealt with

The nature of the cases and much of the client-related work engaged in by social workers has been identified as inherently stressful (Collings & Murray, 1996:384). In order to determine the demands made on the social workers, the nature of the cases dealt with was investigated. The respondents also had to indicate the type of cases dealt with and list the five most common cases, which are reflected in Figure 4.4.

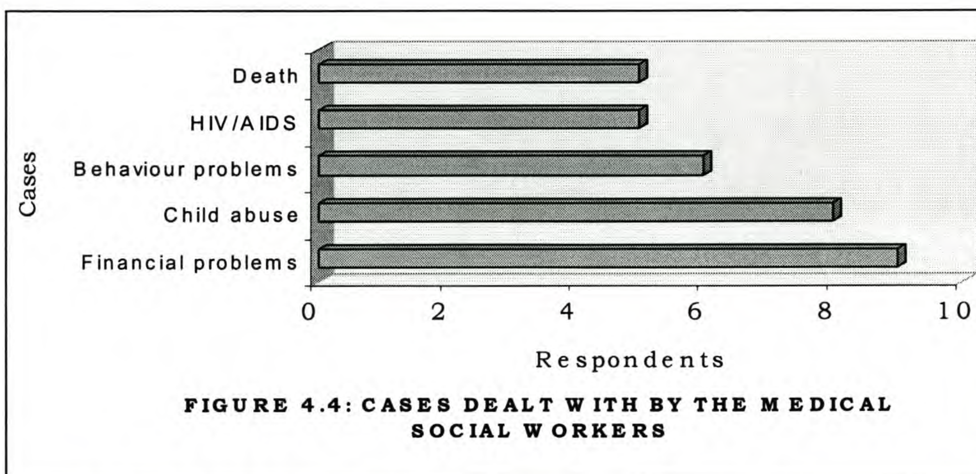

FIGURE 4.4: CASES DEALT WITH BY THE MEDICAL SOCIAL WORKERS

(N=10; more than one response could be given)

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Financial problems and problems related to state grants were indicated by 90 per cent of the respondents as one of the most common problems they had to deal with. The financial situation of the family was relevant as problems within the child's family system affect the child's total functioning and adaptation to hospitalisation (Eiser & Main, 2000:12).

One respondent commented as follows concerning the financial difficulties encountered during intervention:

> *'Problems of unemployment lead to feelings of disempowerment, depression in parents and major financial problems. This impacts negatively on the quality of caring for the children and on fulfilling their basic needs.'*

It appears that the respondent felt inadequate to solve specific client problems, which Collings and Murray (1996:384) identified as a main feature of client-related work contributing to stress. Bennet *et al.* (1993:32) and Gibson *et al.* (1989:3) agreed that client-related work was a great potential source of stress, especially if the social worker became emotionally involved in clients' problems. Stress could lead to burnout and an ineffective work-force if not properly managed (Collings & Murray, 1996:375).

Child abuse was also reported by eight (80%) respondents to be amongst the most common problems dealt with. When dealing with child abuse cases the medical social worker has to assume the role of child protector. Although child protection has been identified as an area in social work practice that is very stressful (Davies, 1998; Chandler *et al.*, 1990) none of the respondents pointed it out as a problem or one of the difficulties encountered in working with hospitalised children. Two respondents mentioned placement, which is an aspect that could be associated with child protection, as creating difficulties. Nevertheless, the findings revealed that child protection was not an area

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perceived by the medical social workers as stressful. This might be due to the fact that medical social workers share the responsibility of child protection with other members of the multi-disciplinary team.

Six (60%) respondents pointed out that *behaviour problems* are amongst the most common cases dealt with. The respondents reported that hospitalised children displayed behaviour problems, which were usually reflected through non-compliance with medical procedures. On the behaviour problems experienced, one of the respondents commented as follows:

> *'Most of the children feel depressed, withdrawn and unco-operative. Those who remain in hospital for long periods often experience additional problems such as maternal deprivation, lack of stimulation and lack of educational opportunities.'*

This response supported the viewpoint that children with a chronic illness had increased rates of behavioural problems and emotional problems and were more vulnerable to internalising problems such as depression (Bennet, 1994:150).

Another respondent commented as follows on difficulties encountered during intervention:

> *'...behaviour problems in children as a result of separation from parents. Children are often tired of staying in hospital, depressed and as a result they act out inappropriate behaviours which lead to non-compliance.'*

Various authors (Berger, 1994; Lewandowski & Baranoski, 1994; Louw & Edwards, 1993;) agreed that separation of children from parents was a traumatic experience with serious consequences for the child. It seemed that hospitalised children often displayed behaviour problems that interfered with their medical treatment. As a result they required social work intervention to

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help them deal with their illness and to gain insight into the consequences of their behaviour.

Cases relating to the *death* of a child were also reported by five (50%) respondents. One of the medical social workers' tasks involves bereavement counselling. The social worker provides counselling to a child who is terminally ill and sometimes to the parents and family members after a child has died. According to various authors (Vos, 1997:40; Ross, 1993:97) bereavement counselling is emotionally demanding and necessitates supportive consultation of the social worker. However, none of the respondents in this study experienced cases dealing with death as a personal problem. This could mean that these social workers are used to attending to such cases of death and in such a way that they did not consider them as stressors and have learnt to cope under these circumstances.

HIV/AIDS-related cases were also identified as one of the most common cases by five (50%) of the respondents. Illnesses with a poor prognosis have a great potential to increase stress in the child (Edwards & Davis, 1997:14). As HIV is not curable, it could greatly increase the stress levels of both the child and the social worker. Ross (1993:98) pointed out that living with such uncertainty, the unpredictable nature of the disease, and fear of the unknown could be extremely stressful for the social worker dealing with people infected and affected by HIV. One respondent noted, concerning HIV-infected children "...a tragedy of dealing with such children". Because the AIDS pandemic is very widespread, social workers might feel helpless in the face of not being able to solve the ongoing problems associated with it. This statement is in support of Ross (1993:97) who found that social workers working with people with AIDS expressed feelings of anger, depression, frustration, despair and powerlessness at not being able to influence the course of the disease.

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4.2.5 Social work intervention

Medical social workers need to choose carefully those practice frameworks that will assist them in rendering appropriate and efficient services to hospitalised children. Practice frameworks in use were also investigated by requesting the social workers to indicate perspectives, theories and models used during social work intervention. The medical social workers pointed out that they used a variety of intervention strategies, underscoring the viewpoint that no one approach is always the best (Sheafor *et al.,* 2000:86). This also indicated that the medical social workers had an eclectic approach during their intervention.

In response to *practice perspectives*, six (60%) respondents indicated that they often provided intervention to the patients' families. Focusing on the patients' families revealed that the medical social workers treated the patients within their own environment, which in turn influenced their functioning. The social workers however, could not name the specific perspectives used, which indicated a lack of knowledge about social work theory. Intervention with clients' families could indicate that the social workers made use of the generalist perspective. Sheafor *et al.* (2000:87) and O'Neil McMahon (1996:3) commented that social workers utilising a generalist perspective were willing and able to focus on a variety of factors that might contribute to problems in social functioning, with an emphasis on systems and their interactions.

As medical social workers often have limited access to resources within the clients' environment, they often refer cases to welfare agencies within the patients' community for further social work intervention. Given the fact that the only resource within the patients' environment that the medical social workers have access to, is usually the family, the social workers might also use the general systems perspective during their intervention, which focuses on how the family influences the child's behaviour and functioning. The finding that the medical social workers often provided intervention to clients' families could indicate use of the general systems perspective, as discussed in Chapter 3.

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None of the respondents mentioned the strengths perspective as part of their practice framework. One respondent however, mentioned empowerment, which was identified by Cowger (1994:263) as an aspect of the strengths perspective central to clinical practice. These findings therefore contradicted the assumption made by Hepworth *et al.* (1997:198) and Cowger (1994:264) as mentioned in chapter 3 that the medical social workers made use of the strengths perspective. It also indicates a lack of knowledge on the part of some of the respondents.

The *practice theories* mentioned by the medical social workers were the behavioural theory and psycho-dynamic theory. Behaviour modification, which is based on the behavioural theory, was indicated by (5) 50 per cent of the respondents as one of the intervention strategies applied. This was consistent with the findings of the current study, which pointed out behaviour problems of hospitalised children that often interfered with the treatment process. Medical social workers have to utilise those intervention strategies that can help decrease behaviour problems so that the child benefits from medical treatment. According to Sheafor *et al.* (2000:98), behavioural theory assists medical social workers in improving the social functioning of the clients by helping them to learn new ways of behaving. Hepworth *et al.* (1997:577) also supported intervention based on behavioural theory but argued that it should not be used as the sole intervention strategy, as all of the relevant factors in the family system should be addressed. Improving social functioning of hospitalised children, with a focus on the influence of the family system on the child's behaviour, would in turn facilitate recovery.

The psycho-dynamic theory was indicated by (4) 40 per cent of the respondents as a theory applied during social work intervention. This theory is based on the belief that unconscious forces that serve a hidden purpose or motive often drive people's behaviour (Sheafor *et al.,* 2000:97). The social workers' focus is on helping people understand the unconscious motivation that influences them, in

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order to facilitate change in their behaviour. According to Sheafor *et al.* (2000:97), the prerequisite for this approach is a client who is motivated, verbal, willing and able to participate actively in a series of regularly scheduled sessions. This implies that the psycho-dynamic theory can only be applied when working with children in the middle childhood stage, specifically those above the age of ten years as they have the ability to reflect on their own thoughts and feelings.

The most commonly identified *practice model* was crisis intervention, which was identified by (6) 60 per cent of the respondents. The crisis intervention model is applicable whenever some personal loss or tragedy has suddenly and dramatically affected the functioning of an individual or family (Sheafor *et al.*, 2000:102). Hospitalisation and the threat of a chronic illness in a child often pose a crisis situation for the child and the family, which usually decreases their level of functioning. Sheafor *et al.* (2000:102) and Hepworth *et al.* (1997:391) emphasised the importance of providing an immediate, focused and time-limited intervention, aimed at restoring clients to their pre-crisis level of functioning. Crisis intervention is applicable to the hospital setting as the medical social workers often deal with patients in crisis for a brief period of time and have to provide therapeutic intervention within that period. By using the crisis intervention model the social workers would be able to help patients maintain an even level of functioning.

4.2.5.1 Interaction with other professionals

It was necessary to investigate the interaction between the medical social workers and other health professionals as the medical social worker is an essential member of the multi-disciplinary team who provides insight and understanding of the psycho-social dimensions of the medical circumstances affecting clients and their families (Ross, 1995:1369). The social workers were asked to indicate how often they liaised with other team members during social work intervention. Table 4.3 shows the results.

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Table 4.3: Social work interaction within the multi-disciplinary team

INTERACTION	F	%
Never	0	0
Sometimes	0	0
Often	2	20
Usually	3	30
Always	5	50
Total	10	100

(N=10)

Five (50%) respondents stated that they always liaise with other team members. Three (30%) respondents indicated that they liaise with other team members on a regular basis, while two (20%) mentioned that they did so quite often. This suggested that all the medical social workers did liaise with other members of the multi-disciplinary team to some extent. These findings were in agreement with the statement by Bronstein (2003:297) that trends in social problems and professional practice made it virtually impossible to serve clients effectively without collaborating with professionals from various disciplines. Herbert and Levin (1996:82) and Berger (1994:14) concurred that medical social workers were an important link within the multi-disciplinary team as their knowledge of the clients within their social environment allowed them to act in support of those clients within the team. It is essential for medical social workers to work together with professionals from various disciplines within the hospital in order to provide an effective and efficient service to clients.

Medical social workers often work in multi-disciplinary teams and at times the other team members do not fully understand the role of the social worker. It is in this regard that the role expectation of the social workers was investigated. The respondents were asked whether other professionals had unrealistic expectations of the social worker's role. The results are reflected in Figure 4.5:

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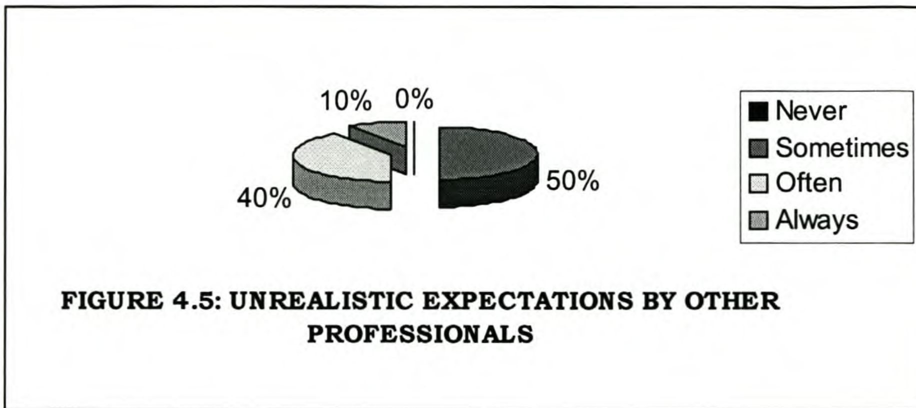

FIGURE 4.5: UNREALISTIC EXPECTATIONS BY OTHER PROFESSIONALS

(N=10)

Figure 4.5 shows that 5 (50%) respondents felt that other professionals sometimes had unrealistic expectations of the role of the medical social workers. None (0%) of the respondents indicated that this never happens. Four (40%) indicated that happened quite often, while one respondent felt that it happened all the time. These findings were consistent with the findings in the literature (Potter, 1998; Jones *et al.,* 1991; Siefert *et al.,* 1991) which reported role conflict experienced by social workers working within a multi-disciplinary team. Botha (2000:201) added that it was not always possible to find an acceptable compromise amongst the professionals and this could result in complications and tension. Role conflict is a risk factor for burnout amongst medical social workers and could negatively affect social work intervention if it is not addressed. However, role conflict was only one of a number of factors that were investigated, which could contribute to burnout amongst medical social workers.

4.2.6 Experiences of burnout amongst medical social workers

The nature of the work of medical social workers is potentially stressful. A variety of work-related experiences influencing burnout were investigated.

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4.2.6.1 Nature of the work

The experience of social work as a job is different for each individual social worker. To collate these experiences the respondents were asked to describe their work as medical social workers by choosing from a list consisting of both negative and positive traits, such as exciting, rewarding, boring, frustrating and stressful. Results are depicted in Figure 4.6.

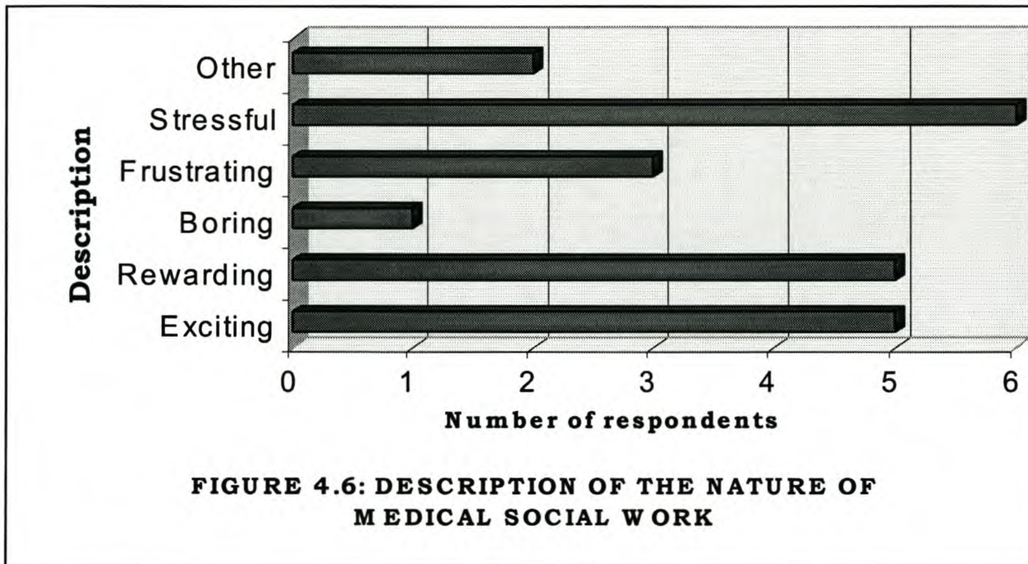

FIGURE 4.6: DESCRIPTION OF THE NATURE OF MEDICAL SOCIAL WORK

(N=10)

The respondents could provide more than one response to this question. A significant number of social workers described their work as stressful. This was consistent with the findings by various authors (Bennet *et al.,* 1993; Siefert *et al.,* 1991) who pointed to social workers employed in child care services and health care settings as having significantly higher stress levels when compared to those in other fields of the social work service. Gibson *et al.* (1989:11) agreed and found the main source of stress amongst social workers to be occupational rather than personal, domestic or political. The work done by medical social workers often involves working under pressure in crisis situations and requires effective results within a limited space of time, which is potentially stressful for the social workers.

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Nevertheless, hospital social work was also viewed as exciting and rewarding by 5 (50%) respondents. These findings corresponded with those of Gibson *et al.* (1989:7) who found social workers to be fairly positive about their work. The findings also contradicted the argument by Potter (1998:6) mentioned in Chapter 3 about the negative attitude of social workers towards their work. Instead, half of the respondents still viewed the job in a positive way even though the nature of their work was stressful. Being positive about the work can thus reduce the likelihood of burnout.

4.2.6.2 Negative emotions

As previously discussed by Potter (1998:6) burnout is characterised by *negative emotions*, which could become chronic and in turn affect the quality of service. A variety of emotions such depression, irritability and lack of concentration were identified in order to determine whether the medical social workers did experience them as a result of their work. The majority (9) ninety per cent of respondents indicated that they sometimes experienced feelings of depression as a result of their work. These findings corresponded with those of Jones *et al.* (1991:464) who also found social workers to be affected with high levels of anxiety, depression and lower levels of job satisfaction. Depression can result in negative attitudes towards work, and hence a decreased level of work performance.

In addition to the feelings of depression, eight (80%) medical social workers also mentioned that they sometimes felt irritated by clients. Such feelings of irritation are often an indication of dehumanisation, which means that the social workers are not responding empathetically towards clients. Ross and Altmaier (1994:14) and Potter (1998:10) identified dehumanisation as one of the symptoms of burnout, which could impact negatively on service delivery.

Furthermore these negative emotions could contribute to a lack of concentration at work, which incidence was also explored with the respondents.

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A significant 6 (60%) of the respondents reported that they sometimes found it difficult to concentrate on their work, which echoed findings by Potter (1998:13) that even when physically present, the person is often emotionally and mentally absent from work. Lack of concentration could be an indication of physical and emotional fatigue, which might in turn contribute to total physical exhaustion.

4.2.6.3 Physical exhaustion

Physical exhaustion is one of the characteristics of burnout and is usually displayed through a variety of symptoms such as headaches, colds, insomnia, backaches, fatigue, weakness and low levels of energy, which could lead to general ill-health (Compton & Galaway, 1999; Potter, 1998; Ross & Altmaier, 1994). The respondents were asked to indicate the presence of the symptoms listed above. The results are shown in Table 4.4.

Table 4.4: Physical symptoms of burnout

SYMPTOM	NEVER	SOMETIMES	OFTEN	TOTAL
Headaches	4	6	0	10
Colds	2	7	1	10
Insomnia	7	2	1	10
Backaches	7	1	2	10
Fatigue	4	3	3	10
Weakness	7	1	2	10
Low energy levels	2	5	3	10

(N=10)

The most commonly experienced symptoms identified by the respondents were headaches, colds and low levels of energy. Six (60%) respondents mentioned that they sometimes suffered from headaches while seven (70%) stated that they also sometimes experienced colds,. Half (50%) of the respondents indicated that they sometimes experienced low levels of energy. Fatigue seemed to be the only symptom that was evenly distributed amongst the medical social workers.

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Four (40%) respondents stated that they never felt fatigue, while three (30%) pointed out that they often experienced it and the other three (30%) indicated that they experienced fatigue only sometimes. These findings indicate that medical social workers had a considerable share of health problems, which Compton and Galaway (1999); Potter (1998) and Ross and Altmaier, (1994) pointed out as one of the symptoms of burnout.

4.2.6.4 The work environment

Work-related stressors were also investigated, as they were indicated as very significant in the incidence of burnout amongst social workers (Collings & Murray, 1996:385). A number of questions dealing with certain aspects within the work environment that often prevented the social workers from coping with the demands of the job, were put to the respondents. The questions focused on recognition by management, remuneration and influence over decisions made by management.

Seven (70%) respondents felt that they did at times receive recognition from management, which differed from the previously mentioned sentiment that people often feel their efforts and outputs are not adequately recognised (Potter, 1998:37). Given their level of qualification and experience, half (50%) of the respondents felt strongly that their salaries were inadequate. Five (50%) respondents felt that they did not have any influence over decisions made by management, which corresponds with the statement that the hierarchical, bureaucratic, organisational structures tend to undermine the autonomy of the social workers and minimise their personal power (Potter, 1998:53; Gibson *et al.,* 1989:8). All the abovementioned stressors could contribute to feelings of powerlessness and demotivation about work, increasing the likelihood of burnout.

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4.2.6.5 Level of job satisfaction

Job satisfaction is a very important predictor of burnout. The respondents had to indicate how often they experienced job satisfaction; the results are summarised in Table 4.5.

Table 4.5: Level of job satisfaction of the medical social workers

LEVEL	F	%
Never	0	0
Sometimes	3	30
Often	5	50
Usually	1	10
Always	1	10
Total	10	100

(N=10)

Five (50%) respondents mentioned that they often experienced job satisfaction while three (30%) stated that they experienced it sometimes. Two respondents mentioned that this happened usually and always, respectively. None of the respondents indicated that they never experienced job satisfaction. This implies that all the medical social workers were, to a certain degree, satisfied with their jobs. These findings complemented those of Jones *et al.* (1991:463) who noted high levels of job satisfaction among social workers, despite the great pressure inherent in the job.

4.2.7 Strategies for reducing stress and promoting job satisfaction

Medical social workers often face great demands during the course of their work, which in turn contribute to stress and may eventually lead to burnout. When there is a discrepancy between job demands and the ability to cope, stress is most likely to increase (Collings & Murray, 1996:376). Based on this premise, the respondents were asked to indicate how they dealt with job-related stress. Results are reflected in Figure 4.7.

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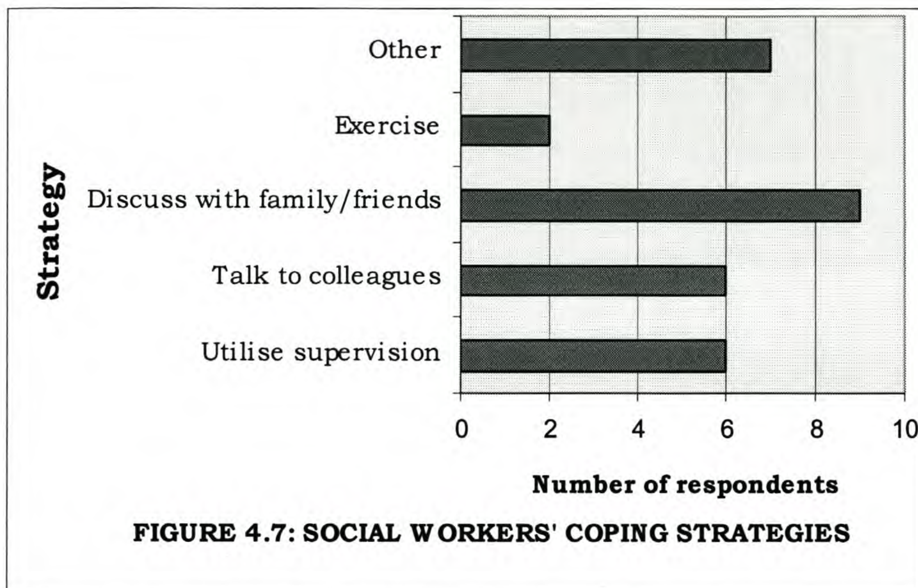

FIGURE 4.7: SOCIAL WORKERS' COPING STRATEGIES

(N=10)

Nine (90%) respondents mentioned that they dealt with their stress through discussion with family and friends. This finding contradicted the statement that social workers did not knowingly burden their families with work-related stress (Gibson *et al.,* 1989:14). Moreover, the findings suggested that for some reason the medical social workers found discussing their work with family and friends helpful. Six (60%) respondents dealt with their stress by talking to colleagues and this supported the findings by Compton and Galaway (2000:500) and Bennet (1993:42) that a person might find it helpful to have regular meetings and informal case discussions with colleagues. Only two respondents mentioned exercise as a means of handling stress, while seven respondents mentioned other strategies such as religion, extra-mural activities, self-preservation behaviours and taking time off. Six respondents indicated that they found supervision helpful in dealing with work-related stress. Jones *et al.* (1991:467) agreed that supervision is important in both supporting workers and controlling the demands on them. Supervision will be discussed further in the section 4.2.7.1.

Given the fact that job satisfaction amongst medical social workers is an important aspect of work performance, the respondents were given an

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opportunity to comment on how to promote job satisfaction. The following strategies were suggested:

- *Setting of goals*

Four (40%) respondents stated that the social workers needed to set goals for themselves, which of course required planning. Compton and Galaway (2000:501) suggested that in trying to reach such goals, the social worker should choose limited objectives that are achievable. Setting goals gives the social worker a sense of direction and purpose.

- *Reducing* work-load

Three (30%) respondents indicated reduced work-loads as one of the factors that might contribute to job satisfaction. Bennett (1993:42), Gibson *et al.* (1989:15) and Jones *et al.* (1991:467) also identified a reduction in work-load as a factor that would alleviate stress and promote job satisfaction. Jones *et al.* (1991:467) added that an investigation of the possibility of improved methods of work-load monitoring and review, coupled with training in work-load management skills, could be the useful in this regard.

- *Recognition/ co-operation from management*

A need for greater recognition of social workers and co-operation from management were also identified. Gibson *et al.* (1989:15) also indicated more support and appreciation from seniors as a significant factor, which could assist in reducing stress and preventing burnout. One respondent used the term 'transparency' to express the necessity of involving social workers in decision-making.

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4.2.8 Job support

Various authors (Botha, 2000:196; Compton & Galaway, 1999:506; Sheafor *et al.,* 1997:182) identified *supervision* as a very important source of support for social workers, in order to guide them in their professional development and to help alleviate job-related stressors and thus promote job satisfaction. The availability and effectiveness of supervision for the medical social workers was investigated to establish the supportive role of the organisations towards the social workers.

4.2.8.1 Supervision

Most respondents, nine (90%) stated that they received supervision within their hospitals and one (10%) respondent indicated that she did not receive supervision. Of the nine respondents, five (50%) received group supervision, two (20%) received individual supervision and the other two (20%) respondents received both group and individual supervision. According to Botha (2000:124) both methods of supervision are of equal importance and have to be planned in accordance with the learning needs of the social workers. It does not matter which methods of supervision are chosen as long as they serve the same purpose. Compton and Galaway (1999:506) and Sheafor *et al.* (1997:182) supported group supervision and recommended that a social worker should build a support group of colleagues with whom he/she felt comfortable and able to share frustrations, as this could enhance work performance and reduce the likelihood of burnout.

Supervision, a major source of social worker support, also seemed to be a potential source of stress to the social worker, when it is was carried out in certain ways (Collings & Murray, 1996:385). The respondents in this study were asked to indicate whether the supervision they received was formal or not. Table 4.6 shows the results.

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Table 4.6: Type of supervision

TYPE OF SUPERVISION	F	%
Formal	7	70
Informal	2	20
None	1	10
TOTAL	10	100

(n=10)

Seven (70%) respondents received formal supervision while two (20%) received informal supervision and one (10%) received none. Botha (2000:211) and Collings and Murray (1996:385) supported a more formal type of supervision and suggest a need for supervisors to be aware of the climate of supervision, which should be positive. Veeran and Simpson (1996:230) agreed that supervision should be directed towards providing a supportive environment conducive to professional development.

An informal and unstructured type of supervision can increase the risk of burnout amongst social workers as it lessens commitment and accountability from both the supervisor and the social worker being supervised. The social worker might end up feeling demotivated and less enthusiastic about his or her work. On the other hand Compton and Galaway (1999:500) argued that informal meetings with colleagues, in addition to supervision, could build a structure of group support for social workers. Formal supervision provided more structure and direction for social workers in their intervention, which in turn promoted lower levels of stress and job satisfaction. As the majority of respondents received formal supervision, it could thus be assumed that the chances of burnout were reduced in this regard.

The availability and provision of supervision does not necessarily mean that it is effective. Jones *et al.* (1991:464) found that support from supervisors was generally viewed as positive and for this reason, the effectiveness of supervision

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was investigated. The respondents were asked to indicate whether they found supervision to be effective. Nine (90%) respondents stated that they found supervision to be effective or not. However only four respondents explained why they felt the way they did. Some of the comments made were as follows:

> *'I gain a lot of support from group supervision.'*
> *'Support from the supervisor ensures that the work is done appropriately.'*
> *'Supervision stimulates me and offers supportive guidance with regard to service delivery.'*

Three of the four respondents mentioned above noted the supportive role of supervision. This supported Veeran and Simpson (1996:230) who stated that people performed best when they felt supported and appreciated. Lack of support from seniors and supervisors was particularly related to high levels of anxiety and depression (Jones *et al.*, 1991:467). The findings indicated that the medical social workers clearly felt supported through supervision.

Compton and Galaway (1999:500) mentioned that informal supervision by colleagues provided an opportunity for workers to talk about their feelings, their defeats, successes and new experiences. The findings in this study agreed with this statement, as supervision was reported to be effective and providing the social workers with an opportunity to debrief and 'de-stress' about difficult cases.

4.2.8.2 Increasing support for medical social workers

Supervision on its own is not enough as a source of support. There are other measures which need to be taken into consideration, that can make social workers feel more supported within the work environment. The respondents were given an opportunity to make recommendations on how to increase

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support for medical social workers. Recommendations consisted of both individually and organisationally based strategies.

Four (40%) respondents pointed out that *time out* from work, in the form of taking leave and going on regular outings would be helpful. This is however, contradicted by Compton and Galaway (1999:506) who argued that taking leisure time was not enough; rather it should be used for personally rewarding activities, such as fostering personal relationships and exploring personal interests. Sheafor *et al.* (1997:181) agreed that social workers should seek opportunities to take breaks during their working day and do something different for a change from their work. Taking time out from work therefore, does not necessarily mean that medical social workers should take a long vacation from work, but that they could start by developing interests and hobbies that stimulate them both mentally and physically.

Two (20%) respondents mentioned *self-care* as one of the strategies that could be used in order to increase support for social workers. This corresponded with suggestions made by Compton and Galaway (1999:498) and Sheafor *et al.* (1997:181) that social workers needed to cultivate self-awareness and take time to recognise the positive elements in both their personal and professional lives. Social workers needed to balance their lives and be careful not to overly involve themselves in their work and in their client problems, as this is a potential risk for stress and burnout. Compton and Galaway (1999:498) agreed that social workers should work at knowing and accepting themselves, at knowing what they could do and accepting what they could not. By balancing their personal and professional lives, social workers could reduce the likelihood of burnout.

Two respondents commented on the need for regular *forums and meetings* between the medical social workers from various hospitals. Botha (2000:214) and Veeran and Simpson (1996:231) agreed that supervisors should keep abreast of new developments in the field of social work, encourage reading and

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facilitate attendance at workshops, conferences and meetings involving other social workers. Social workers could greatly increase their professional development in this regard.

4.2.9 Summary

The research findings contained in this chapter identified a variety of symptoms experienced by medical social workers, which are risk factors of burnout. The findings described certain aspects of job-related stressors that were identified by the medical social workers as contributing to burnout. Most of the findings correlated with the literature study conducted in Chapter 2 and 3 of this report.

Strategies for reducing stress and burnout were discussed, which could be used as guidelines for promoting job satisfaction amongst medical social workers. This in turn corresponded with the main objective of the study, which is to provide guidelines for handling stress among medical social workers working with hospitalised children in order to promote job satisfaction and enhance work performance. The role of supervision as a source of support was also examined and a few suggestions were made on how to increase support for social workers.

The guidelines formulated through the empirical study will contribute to an understanding of effective ways to deal with work-related stress, which can in turn promote efficiency in service delivery.

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CHAPTER 5

CONCLUSIONS AND RECOMMENDATONS

5.1 INTRODUCTION

Burnout is an advanced stage of stress that can negatively affect the social worker's effectiveness when it occurs. Medical social workers working in children's wards are often at risk of burnout because of the stressful nature of their work. The circumstances relating to hospitalised children were discussed in Chapter 2 in order to illustrate the demands put on the social worker that has to deal with those children. The role of the medical social worker in dealing with hospitalised children was discussed in Chapter 3, with an emphasis on factors influencing burnout. An investigation of these factors was done through an empirical study in an attempt to achieve the aim of the study, which was to formulate guidelines for handling stress among medical social workers in order to promote job satisfaction. As a result of the findings in the literature and the empirical study, conclusions and recommendations will be made in the following sections of this chapter.

5.2 CONCLUSIONS

The conclusions will be discussed according to the main aspects that were investigated in the empirical study namely identifying details of the respondents, case load, social work intervention, burnout experiences and job supports.

5.2.1 Identifying details of the medical social workers

Vulnerability to burnout is related to age. The younger the social worker the more she/he is likely to experience burnout The study showed that the majority of the medical social workers were young (under the age of 35 years) which made them more prone to burnout. Gender was not a relevant aspect, as both men and women experienced burnout in a similar fashion.

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The period of service in the hospital indicated that there had been a constant turnover of social workers in the hospitals within the last five years. The findings also indicated that the younger social workers had changed jobs at least once within the last five years as compared to the older social workers who had been working in the hospital for longer periods of up to 28 years. The fact that older social workers had been in the hospital for longer might indicate that they had learnt to overcome job-related stressors and developed effective coping mechanisms. As a result they were less likely to experience burnout. However, the level of employment of the medical social workers could negatively affect enthusiasm for their work, as chances of promotion were very slim regardless of their years' experience.

5.2.2 Case load of the medical social workers

Having a large case load is a significant predictor of job-related stress, which in turn contributes to burnout. Medical social workers are faced with large case loads that they have to attend to on a monthly basis. The majority of these cases relate to hospitalised children, especially those in the early and middle childhood stages. The level of understanding of these children requires social work intervention to help them understand the implications and consequences of an illness. This can be stressful for the social worker who has to work according to the child's level of understanding.

The nature of cases dealt with by social workers is a strong predictor of stress. Generally, problems within the child's family system negatively affect the child's functioning as well as the ability to adapt to hospitalisation. The most commonly identified cases relate to financial problems within the family, which in turn affect the quality of home care for the children. These problems in turn hinder the child's recovery. In this study and in contrast to the findings of other authors in the literature, child protection was not regarded as stressful by the medical social workers. This could be attributed to the fact that medical social

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workers shared the responsibility of child protection with other members of the multi-disciplinary team.

Behaviour problems, as a result of separation from parents, emerged as significant in cases encountered by medical social workers when dealing with hospitalised children. Cases relating to death and HIV/AIDS were also identified as amongst the most commonly cases dealt with. Due to their unpredictable nature, these cases also had a negative effect on the child's condition and provoked feelings of anxiety in the social worker.

Increased work-load and the nature of cases dealt with could thus be regarded as potential stressors for the medical social worker, which could in turn contribute to feelings of anxiety and depression.

5.2.3 Social work intervention

In rendering services to hospitalised children, social workers have to choose carefully those practice frameworks that are most suitable for their intervention. The social workers are eclectic in their approach, as no one approach is always best. This implies that they are free to focus on other factors within the child's environment that might be contributing to the problem. Practice frameworks include a combination of perspectives, theories and models, which are applicable to the hospital setting.

The most commonly used perspectives are the generalist and the general systems perspectives, which focus on the role of the family in the child's functioning. As a result of the behaviour problems often displayed by hospitalised children, medical social workers base their intervention on behaviour theory, which places the emphasis on behaviour modification. This intervention strategy focuses on altering the inappropriate behaviours in order to promote recovery. The psycho-dynamic theory seems to be guiding the social

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workers in their intervention, but this is impossible to apply when working with children in the early childhood stage.

The most commonly applied model in working with hospitalised children is crisis intervention, as medical social workers often work in crisis situations. The emphasis is on providing an immediate, focused and time-limited intervention, which is aimed at restoring clients to their pre-crisis level of functioning. These theoretical frameworks provide structure and directive to social work intervention, which in turn promotes job satisfaction amongst medical social workers.

Trends in social problems and professional practice however, make it virtually impossible to serve clients effectively without collaborating with professionals from various disciplines. Differences of opinion often occur within the multi-disciplinary team, especially when other team members have unrealistic expectations of the social worker's role. This can contribute to role conflict amongst the professionals, which in turn results in tension. It can thus be concluded that role conflict experienced by medical social workers within the multi-disciplinary team could contribute to stress and burnout.

5.2.4 Experiences of burnout amongst the medical social workers

Medical social work involves working in crisis situations, under pressure and requires an effective result within a limited space of time, all of which are potentially stressful for the social workers. Despite the stress experienced, medical social work is still regarded as exciting and rewarding.

Burnout is characterised by negative emotions such as depression and irritability, which can eventually become chronic and in turn affect the efficacy of service delivery. It was established from the findings that the social workers at times experienced a lack of concentration in their work, which could in turn

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contribute to a decreased level of work performance and could increase the likelihood of burnout.

Physical exhaustion is one of the characteristics of burnout, which is usually displayed through a variety of symptoms such as headaches, colds, insomnia, backaches, fatigue, weakness and low energy levels. This of course affects the social workers' general health. It was established from the findings that the medical social workers had a considerable share of these health problems, which puts them at risk of burnout.

Certain aspects within the work environment were significant predictors of stress that put demands on social workers and increased the likelihood of burnout. These aspects related to inadequate remuneration, lack of recognition from management and an inability to influence decisions. The bureaucratic organisational structures also contributed to feelings of powerlessness and demotivation amongst social workers and therefore increased the likelihood of burnout.

5.3 RECOMMENDATIONS

On the basis of the findings and conclusions of the research, the following recommendations are made, which might assist medical social workers in dealing with work-related stress and in turn reduce the likelihood of burnout.

5.3.1 Identify possible stressors

As a guideline to reduce job-related stressors, social workers need to learn to identify certain aspects of their work, which are potential stressors and to find effective ways to deal with them. It is recommended that social workers make use of a combination of organisationally and individually based strategies in order to overcome job-related stress.

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5.3.2 Stress reduction strategies

When dealing with work-related stress, the following strategies are recommended:

- **Case discussions**

In order to deal with the overwhelming feelings evoked by certain cases, social workers have to find forums to discuss these issues. The nature of such discussions can be formal or informal and can be done with colleagues, family and friends. The social workers however, need to keep in mind the principle of confidentiality when engaging in such discussions.

- **Setting goals**

In their work social workers need to plan ahead by setting goals for themselves. It is important that limited objectives that are realistic and achievable, should be selected. Setting goals gives the social worker a sense of direction in his or her work and ensures a purposeful approach.

- ***Managing* work-load**

Social workers need to develop more control over their work-load. An investigation into the possibility of improved methods of work-load monitoring and review, coupled with training in work-load management skills, could be useful. Learning to manage work-load in this way can reduce the amount of the size thereof.

- **Job descriptions**

Medical social workers should have a written job description, which can function as a point of reference and assist in alleviating role conflict. They therefore, need to set clear boundaries and clarify their roles within the hospital setting.

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- **Taking time out**

Taking time out from work in the form of leave, lunch or breaks can help the social worker get away from the stress of his or her work. This time out should be used to explore personal interests and extra-mural activities, which can reduce stress levels. It can be used to pursue activities or interests such as exercise, religious faith, meditation and other leisure activities.

5.3.3 Job support

The hospital management has to play a significant role in providing support for medical social workers by promoting the following:

- **Supervision**

Supervision is a very important source of support for social workers. It guides them in their professional development and can help alleviate job-related stressors and promote job satisfaction. It is therefore recommended that social workers receive supervision from superiors on a regular basis in order to ensure motivation and accountability. Proper supervision can therefore increase the effectiveness of social work intervention.

- **Stress reduction programmes**

Stress reduction programmes need to be made available to social workers by the hospital management. However, social workers should take the initiative to enrol in such programmes. Training in personal stress management techniques should be part of those programmes.

5.3.4 Further research

It is recommended that further research be conducted into the following areas:

- The effectiveness of supervision in promoting job satisfaction.
- The experience of stress and burnout amongst medical social workers dealing with both adults and children.

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- The impact of personal stress on the social workers' job performance.

5.4 SUMMARY

Several conclusions and recommendations were made based on the findings of this study. As demonstrated in this chapter, the goal of the study was achieved, which was to provide guidelines for handling stress amongst medical social workers working in paediatric wards in order to promote job satisfaction and enhance work performance.

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APPENDIX 1

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UNIVERSITY OF STELLENBOSCH
DEPARTMENT OF SOCIAL WORK
ENQUIRIES: NOMVUYO LUKELELO
(021) 658 5196/5348 OR 083 6944337

Medical social workers dedicate themselves very much to their work and in the process ignore their own emotional and mental health. This questionnaire is aimed at identifying factors that contribute towards burnout amongst medical social workers working with children in hospital wards. Please answer the questionnaire as honestly as possible. The information will be treated with strict confidentiality.

AN INVESTIGATION OF BURNOUT AMONGST MEDICAL SOCIAL WORKERS WORKING IN CHILDREN'S WARDS

QUESTIONNAIRE FOR SOCIAL WORKERS

Please answer the following questions by marking with an X where applicable and/or writing in the spaces provided.

A. IDENTIFYING DETAILS OF MEDICAL SOCIAL WORKER

1. Age ____________________
2. Gender ________________
3. Marital status Single ☐ Married ☐ Divorced ☐ Widowed ☐
   Separated ☐ Other ☐ Please specify ________________
4. Academic qualifications ____________________________________
5. Years of service in the hospital ___________________________
6. Years of service as a social worker ________________________
7. Rank ____

B. CASE LOAD

1. What is your total caseload for the month of September 2003? ________
2. What is the number of children that you deal with monthly?

   ____

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3. What are the ages of the children that you deal with? (please indicate the average percentage of your total case load per month)

Age	%
0-2 years	
3-6 years	
7-12 years	
13-18 years	

4. Medical diagnosis. Which of the following cases do you deal with during a month?

Child abuse		Ingestion	
Transplant assessments		Grants	
Behaviour problems		Consent	
Attempted suicide		Placement	
Psychiatric problems		HIV/AIDS	
Terminal illness		Death	

OTHER specify ______________________________
____

5. From your caseload, list the five most common cases dealt with, from the most to the least common.

____

____

____

____

____

6. What kind of problems or difficulties do you encounter in working with hospitalised children? ______________________________
____
____

C. SOCIAL WORK INTERVENTION

1. Indicate which model(s) you utilise during social work intervention ______________________________

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____

____

2. Indicate which perspectives directs you during social work intervention

____

____

3. Indicate which theories you utilise during social work intervention

____

____

4. Name the techniques most often utilised during intervention

____

____

5. How often do you liase with other members of a multi-disciplinary team during social work intervention?

Never		Sometimes		Often		Usually		Always	

6. Do other professionals have unrealistic expectations of your role?

Never		Sometimes		Often		Usually		Always	

D. WORK RELATED EXPERIENCES INFLUENCING BURNOUT AMONG MEDICAL SOCIAL WORKERS

1. How often do you experience job satisfaction?

Never		Sometimes		Often		Usually		Always	

2. How would you describe your work as a medical social worker?

Exciting	
Rewarding	
Boring	
Frustrating	
Stressful	

Other, specify ______________________________

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Motivate____

3. Do you experience feelings of depression as a result of your work?

Never		Sometimes		Often		Usually		Always	

4. Does your job cause you to feel irritable and to snap at people?

Never		Sometimes		Often		Usually		Always	

5. Do clients irritate you?

Never		Sometimes		Often		Usually		Always	

6. Is it difficult for you to concentrate on your work?

Never		Sometimes		Often		Usually		Always	

7. Do you get ill a lot more than you did the previous year?

Yes		No	

8. Indicate which of the following you experience.

Symptom	**Never**	**Sometimes**	**Often**
Headaches			
Colds			
Insomnia			
Backaches			
Fatigue			
Weakness			
Low energy level			

9. Do you experience stress as a result of your work?

Never		Sometimes		Often		Usually		Always	

10. Please indicate how you deal with work related stress (more than one can be indicated)

Utilise supervision	
Talk to colleagues	
Discuss with family, friends	
Exercise	
Other	

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11. Do you use any of the following substances to help you cope with your work load?

Substance	**Never**	**Sometimes**	**Often**
Alcohol			
Tranquillisers			
Sleeping pills			
Headache pills			
Mood elevators?			

12. Do you feel that your efforts and outputs are recognised by management?

Never		Sometimes		Often		Usually		Always	

13. Taking into account your qualifications and experience, do you find your salary appropriate?

Definitely not		No		Not sure		Yes		Definitely yes	

14 Do you experience difficulty in meeting deadlines?

Never		Sometimes		Often		Usually		Always	

15. Are the rules and policies of the hospital easily accessible to you?

Never		Sometimes		Often		Usually		Always	

16. Do you have an influence over decisions made by management?

Never		Sometimes		Often		Usually		Always	

17. Have you thought about leaving your job in the last 12 months?

Yes ☐ No ☐

18 What is the likelihood that you will leave your job in the next 12 months?

Definitely not		Not likely		Not sure		Likely		Very likely	

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19. What would you consider doing?

Find new employment	
Resign and stay at home	
Change career	
Other-specify	

20. What other factors do you think might promote job satisfaction in order to prevent burnout amongst medical social workers?

____

____

____

____

____

E. JOB SUPPORT

1. Do you receive social work supervision? Yes ☐ No ☐
2. What kind of supervision do you receive?
   Individual ☐ Group ☐ Other-specify ____________
3. Is it a formal supervision? Yes ☐ No ☐
4. How often do you receive supervision?

Monthly	
Weekly	
Daily	
On request	

5. Do you find supervision effective? Yes ☐ No ☐
   Please motivate

   ____

   ____

6. Do you have any recommendations on how to increase support for medical social workers?

____

____

____

THANK YOU