

## Bringing Sanctuary to Dialysis

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*The demands of the chronically ill elderly population, underutilization of end-of-life care in dialysis, and the projected nursing shortage will have serious implications for dialysis staff care over the next decade. Little information exists regarding the effects of emotional labor on the dialysis staff and patient outcomes, or about effective programs that can be used to specifically address compassion fatigue in the dialysis unit setting. Masters-level social workers have the necessary training to facilitate in-center programs to reduce compassion fatigue symptoms, improve staff satisfaction and patient outcomes. The following article outlines a structured intervention aimed to address effective management of emotional labor experienced among dialysis unit professionals using the trauma-informed approach of the Sanctuary Model.*

*“Blessed is the influence of one true, loving human soul to another.”—George Eliot*

### BACKGROUND AND SIGNIFICANCE

The dialysis unit is unlike any other medical setting. Dialysis patients with end-stage renal disease (ESRD) represent a unique population that is distinguished by a significant burden of disease and high mortality rates (Haras, 2008). ESRD census projections for 2020 reveal significant implications for clinical practice, based on the increasing rate of diabetes, rising mortality, advances in medical technology, and the expanding aging population (USRDS, 2014). Additionally, the multiple comorbidities that often accompany ESRD will pose continuing challenges for clinical management of this population (CDC, 2010; USRDS, 2014). Effective clinical management of patients in dialysis unit settings can be achieved when best practices address both the needs of the patients and staff (Laschinger, Sabiston, & Kutzher, 1997). Renal social workers' extensive training and skills can ensure that such practices are implemented in dialysis units (Council on Social Work Education, 2008; Lowrie, Curtin, LePain, & Schatell, 2003).

An understanding of the dialysis unit and the needs of staff are essential for patient and staff satisfaction. Given the high burden of patient symptoms, attention to staff interventions that acknowledge the role of emotional trauma, such as feelings of intense fear, helplessness, and detachment associated with renal disease needed. Although little is known about emotional trauma as it specifically relates to dialysis patients, evidence suggests that, in general, chronic illness can result in physical, mental, and emotional trauma for patients (Seifter, 2010). Treatments associated with dialysis, such as multiple hospital admissions, surgeries, medications, and dialysis treatment itself, may result in depression, anger, social withdrawal, or hypervigilance (Seifter, 2010). When this occurs, dialysis staff can be greatly impacted as a result of continuous exposure to patient symptoms. Researchers suggest that healthcare providers are often particularly vulnerable to emotional and spiritual consequences, such as feeling disconnected from work that used to be mean-

ingful, or having marked negative cognitive schemas as a result of continuous exposure to trauma and a therapeutic relationship that mandates “empathic openness” (Dunkley & Whelan, 2006; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). “Empathic openness” involves being aware of and open to the pain of others and using of appropriate and responsive emotions to attend to that pain (Pearlman, 1999). In the dialysis unit setting, nurses and technicians often share a considerable amount of time and space with patients. This unique relationship can result in feelings of dependency among patients who rely daily upon the staff to keep them alive, and can have a further impact on how staff connect with their clients and facilitate healing. Staff must often be fully present by giving deliberate and focused attention to patients, while attending to the emotional and physical needs of both patients and their families. The emotional nature of these interactions, where workers are expected to display certain feelings to satisfy organizational and professional expectations, has been termed “emotional labor” (Hochschild, 1983). This can be a deep or surface exchange. In the nursing profession, caring as a form of emotional engagement is seen as essential to practice, but is best managed through training and preparation (Bolton, 2000; Craig & Sprang, 2010; Henderson, 2001; McQueen, 2004).

In a supportive work environment, emotional labor can foster deep satisfaction, increase compassion, and build resilience in workers (Craig & Sprang, 2010; Grandey, 2000; Miller, Birkholt, Scott, & Stage, 1995). On the other hand, repeated exposure to work-related stress, without adequate support and built-in buffers, can trigger a compassion fatigue response, including short-term emotional exhaustion (Bolton, 2000; Bride, 2007; McQueen, 2004). As emotional resources are depleted, workers feel they are limited in how they care for others (St. Pierre, Buerschaper, Hofinger, & Simon, 2011). This is particularly important for human service providers whose job roles require emotional

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labor. If not addressed, compassion fatigue may lead to the long-term maladaptive response of burnout that may induce some to leave the profession, or in worse case scenarios, continue to practice in a disconnected manner (Bride, 2007). Furthermore, in dialysis settings where futility of care may occur, staff may experience vicarious traumatization, which is psychological distress that can result when staff empathically engages with their patient's individual trauma (Pearlman & Mac Ian, 1995; Sabo, 2011). The workers may begin to reassess their reality, and there may be an inner transformation that negatively colors their world-view (Pearlman & Saakvitne, 1995). Constant exposure to traumatic events, such as death, dying, and chronic illness, can have a cascading negative effect on staff, and result in what is referred to as a "Negative Tetris Effect." Achor (2010) describes this phenomenon as a pattern of thinking that focuses overwhelmingly on negative aspects of both professional and personal life. Furthermore, this "pessimistic or fault-finding view of the world can make staff more susceptible to depression, stress, poor overall health, and substance abuse" (Achor, 2010, p. 93).

Due to the complexity of the dialysis unit setting and treatment needs of clients, the well-being of nurses and dialysis staff who provide daily interventions should be adequately addressed to ensure positive outcomes for staff and clients. Coping strategies for dialysis staff and responses to patient trauma can have an impact on work-related stress (Hayes, & Bonner, 2010). If left unaddressed, poor reactions to workplace stress can lead to distress and burnout among dialysis care providers and decreased patient satisfaction (Laschinger & Leiter, 2006; Sudhaker & Gomes, 2010). This is harmful to patients, caregivers, and dialysis staff, and can be costly to the unit.

Trauma-informed interventions will be especially meaningful for dialysis staff who have continuous exposure to patients' and families' distress. A clear focus on staff needs, including adjustment and coping with the emotional and physical demands is vital for staff satisfaction, staff retention, and positive patient outcomes. Master's-level renal social workers can best provide trauma-informed interventions for dialysis staff. Graduate social work education prepares students for competent trauma-informed practice, because social workers specialize in treating trauma survivors (Council on Social Work Education, 2008). Trauma studies have gained considerable attention over the past 30 years (Abigail & Wilson, 2005; Balaev, 2008; Caruth, 1996; Herman, 1997). This era provided a base of scholarship that included investigation into the effects of chronic stress and the neurobiological consequences of emotional dysregulation (Felitti et al., 1998; Pynoos, Steinberg, & Goenian, 1997; Schore & Schore, 2008). This research provides the empirical support for clinical and organizational interventions, including the Sanctuary Model (Bloom & Farragher, 2010).

Schools of social work now incorporate trauma theory and treatment in their curricula through individual courses or

trauma treatment certification programs (Breckenridge & James, 2010; Bussey, 2008; Cunningham, 2004; McDonald et al., 2007; McKenzie-Mohor, 2004). The School of Social Work at the University of Buffalo has integrated its entire MSW curriculum with a trauma-informed and human rights perspective. Although it is likely that most trauma-informed practice is found in mental health settings and with affected families and children, application of this practice to the dialysis unit setting is worthwhile given the setting and the potential consequences to patients if best practices are not consistently applied.

Following is a proposal for introducing Bloom and Farragher's (2010) trauma-informed psychoeducational intervention called Safety Emotion Management Loss and Future (SELF) into an existing hospital-based dialysis unit. SELF is one of the three core components of the Sanctuary Model. The Sanctuary Model is a therapeutic milieu that is theoretically and empirically founded on trauma theory (Bloom, 1997). This proposal will utilize a case example from the author's personal experience. It will include an overview of the dialysis setting as it relates to organizational stress, an introduction to the Sanctuary Model, and a review of SELF and how this intervention could be applied using the case example. Barriers to implementation, as well as suggestions and recommendations for ensuring sustainability and success of the model, will be included.

## THE DIALYSIS UNIT

### *Environment*

The dialysis unit setting is complex and demanding (Dermoddy & Bennett, 2008; McVicar, 2003). Although the dialysis unit environment and staff have an impact on patient outcomes, few studies have focused on these subjects. Research indicates that important patient outcomes (e.g., serum albumin levels and compliance with treatment) are positively correlated with patient perceptions of staff and dialysis unit characteristics (Argentero, Dell'Olivo, Santa Feretti, & Working Group on Burnout, 2008; Kaveh & Kimmel, 2001; Kimmel, 2000). More studies are needed in this important area.

### *Staff*

Medical professionals who work in dialysis units represent a unique group who are required to balance the pervasive needs of patients with unremitting changes in healthcare (O'Brien, 2010). Although advancements in treatment contribute to the overall survival of dialysis patients, health-related quality of life (HRQOL) remains low as compared to the general population and is a predictor of risk for patient mortality and hospitalization (Fukuhara et al., 2003; Mapes et al., 2003).

Dialysis nurses and technicians must provide patient-centered care with a level of confidence and empathy that result in supportive and effective treatment in the face of these challenges. These professionals are exposed to more

aspects of the patients' care than other members of the healthcare team, including moments when patients are emotionally or physically not well. For patients with physical limitations, many dialysis staff members must tend to the patients' during treatment. These tasks could be as simple as repositioning the patient, or as time-consuming as cleaning up after a bowel movement. The staff may also spend part of their time listening to patients discuss their feelings on loss and grief especially when the patients have multiple comorbidities. Many dialysis patients face multiple losses beyond their kidney function that can involve relationships, sexuality, and independence (Chilcot, Wellsted, & Farrington, 2008). Additionally, this population experiences more hospitalizations than individuals without CKD and at increasing rates as the illness advances (USRDS, 2014).

### *Aging Population*

Although not all dialysis patients have had a past or present traumatic life event, research suggests that many dialysis patients, especially older patients with multiple comorbidities experience chronic stress and poor coping, often related to pain and discomfort (Lopes et al., 2004). Attention to the needs of older adults is particularly important as it relates to trauma-informed interventions, given the increase of this population in dialysis unit settings. Those aged 65 and older continue to represent that fastest growing number of patients with CKD and ESRD. Furthermore, compared to those without ESRD, this group has a higher risk for mortality (USRDS, 2014). In general, dialysis patients over 75 are typically diagnosed with more than 3 medical problems (Anand, Kurella Tamura, & Chertow, 2010). The addition of dialysis to the aging process results in a disease trajectory that involves frequent hospitalizations, acute physical complications, multiple comorbidities, high symptom burden, caregiver stress, and declining mental health (Swidler, 2010). Older patients experience multiple symptoms, such as pain, fatigue, insomnia, unintentional weight loss, neuropathy, and depression (Swidler, 2010).

### *Mental Health*

As CKD and ESRD prevalence rises in this population, the incidence of functional disability, cognitive dysfunction, and depression is increasing (Swidler, 2010). The multitude of physical and psychological problems can lead to chronic stress and cumulative trauma in many adults who receive dialysis treatment. Multiple losses, combined with fear of dying and dependency upon treatment can also result in high levels of depression among this population (Davison, 2007; Kimmel, 2000; Sledge et al., 2011; Watnick, Wang, Demdura, & Ganzini, 2005; Wuerth, Finkelstein, & Finkelstein, 2005). Despite reports of high depression rates in dialysis patients, few receive treatment for their symptoms (Chilcot, Wellsted, & Farrington, 2008; Guzman & Nicassio, 2003; Sledge et al., 2011). This could potentially influence the culture of the dialysis unit setting and the relationship between dialysis patients and staff.

All of these aspects of care can create a high-stress environment for staff working in a dialysis unit setting, making the need for a supportive and safe work environment essential to ensure the well-being of both staff and patients. Safe work settings are predictable, even in fast-paced and reactive units, and employees know where to get help. Bloom and Farragher (2010) suggest that exposure to chronic stress without adequate organizational and individual support can lead to workers to become emotionally dysregulated (have emotional responses that are poorly modulated) and feel disconnected from their work. Chronic emotional arousal can deplete emotional energy and reduce empathic concern, which is the ability to respond with warmth and compassion. This increases personal distress, which generates anxiety and discomfort from watching others suffer (St. Pierre, Buerschaper, Hofinger, & Simon, 2011). Bloom and Farragher (2010) assert that the absence of empathic concern can have an impact on the provider's ability to emotionally regulate and result in occupational dissatisfaction and burn-out (Pearlman & Saakvitne, 1995). When this happens, a distressed organization can become more authoritarian in their treatment delivery and less deference is given to complex processing that creates responsive and tailored treatment for individuals and groups within the organization (Brehmer, 1992; Gary & Wood, 2011; Gigerenzer & Gaissmaier, 2011; Wood & Bandura, 1989). Trauma-informed education and training programs provided by licensed renal social workers can help prevent occupational dissatisfaction among staff. The Sanctuary Model is an example of a trauma-informed approach that has been successfully applied in various human service organizations (Bloom & Sreedhar, 2008). This model is informed by trauma theory (Herman, 1997), constructivist self-development theory (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), systems theory (Bertalanafy, 1974), and complexity theory (Waldrop & Gleick, 1992), and is potentially applicable to the dialysis unit setting.

### *The Sanctuary Model*

The Sanctuary Model is based on theories of trauma and attachment, and examines how an individual's need for safe, nurturing and a predictable social environment is essential and reflective of physical, cognitive, and emotional responses to danger (Fonagy, 2001; Schore, 2001). This model is further supported by seminal research, such as the Adverse Childhood Experiences (ACE) Study, which demonstrated the link between adverse and traumatic life experiences and deleterious health outcomes (Felitti et al; 1998). The study demonstrated the need for the implementation of trauma-informed practices in organizations that have a high percentage of clients who present with poor coping and adjustment as a result of both past and present traumatic experiences (Felitti et al., 1998). The core components of the Sanctuary Model are (Bloom, 1997):

- Theoretical values and assumptions that derive from trauma theory

- Seven core commitments that articulate the above values
- SELF framework for problem solving and shared language

The conceptual framework of the Sanctuary Model and the application of the SELF Model to the dialysis setting can be found in [Figure 1](#).

**The Model for Care: SELF**

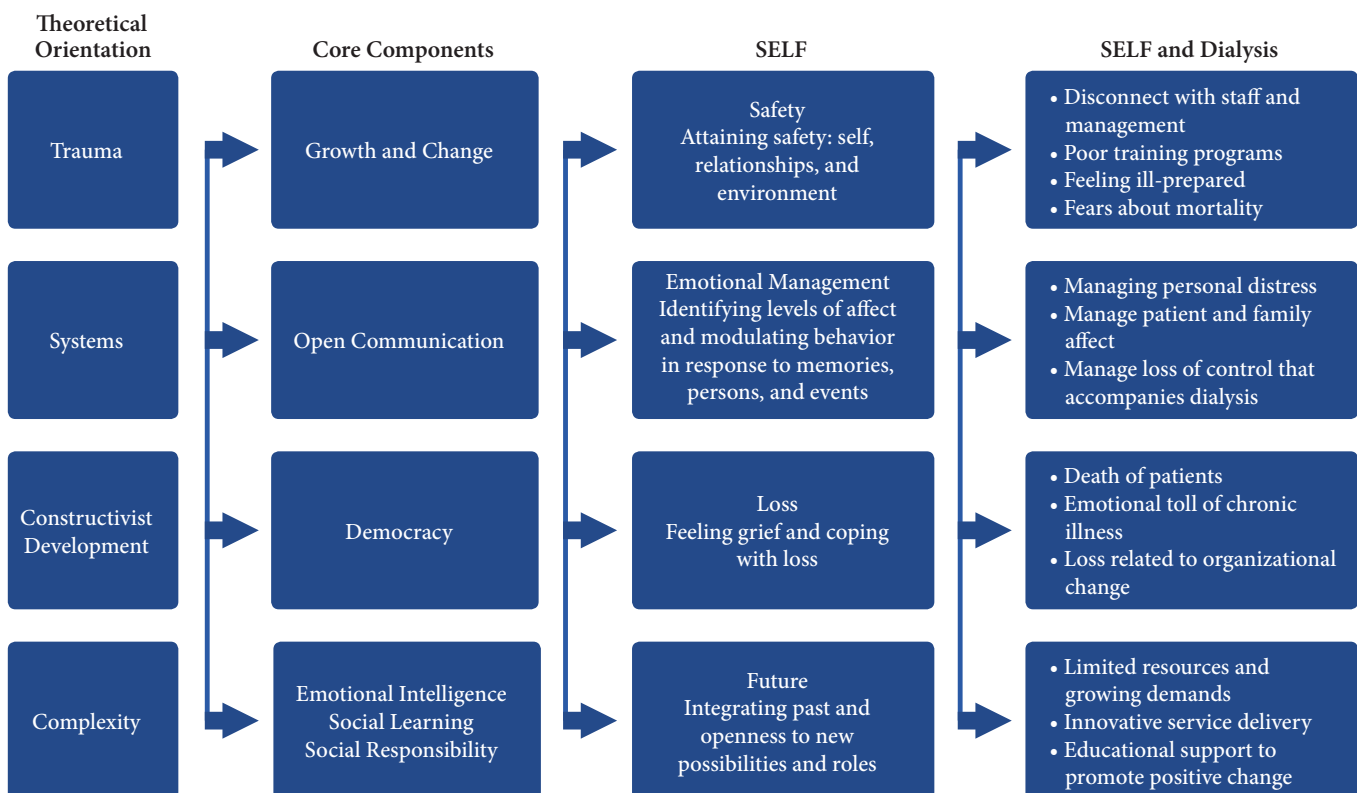
A component of the Sanctuary Model, the Safety Emotion Management Loss and Future (SELF) Model is a nonlinear framework for formulating plans for client services and treatment, as well as processing organizational and interpersonal issues. The SELF Model provides a template for organizational change that is grounded in trauma-informed practice, and was originally developed for an in-patient psychiatric setting for adults who experienced trauma in early childhood (Bloom & Farragher, 2010). Trauma-informed models are frameworks to manage the impact that past and current adverse life experiences and traumas have on the day-to-day functioning of individuals, and how these injuries may have an impact on recovery for patients. Trauma-informed models aim to create systems that are emotionally safe for all members of the organization, including the well-being of the service providers. Principles of trauma-informed care include: a) understanding the impact of trauma on how people adapt and relate; b) creating and promoting safety; c) supporting choice and autonomy; and d) conducting engagement, assessment,

and intervention in a theory-driven and sequential manner (Fallot & Harris, 2002).

The SELF Model incorporates these principles and has demonstrated success in various human service organizations serving diverse populations, but has not been implemented in a dialysis unit setting (Abramovitz & Bloom, 2003; Bloom et al., 2003; Bloom & Sreedhar, 2008; Madsen, Blitz, McCorkle, & Panzer, 2003). The theoretical conceptualization of the SELF Model is grounded in empirical data and suggests that therapeutic milieus and social service organizations can use democratic processes to make complex decisions. These systems engage clients by focusing on the many domains of safety: psychological, spiritual moral, and social. This information is used to create responsive interventions (Bloom & Farragher, 2010; Esaki et al., 2013).

Although this model of care has been primarily utilized for social service organizations serving psychologically injured individuals, there is evidence suggesting it may be appropriate for the dialysis unit setting, including recent trauma work in pediatric oncology and medical trauma centers (Kassam-Adams et al., 2014; Kazak et al., 2006; Pynoos et al., 2008). Knowledge from these reports can aid in better understanding how trauma-informed approaches could be useful in various healthcare settings where patients often experience high symptom burden and high rates of mortality, such as in dialysis. For example, Kazak et al. (2006) found that when a medical oncology unit was given psycho-education on the impact of trauma on functioning, they could better respond to the emotional needs of the clients and the families that

**Figure 1.** Sanctuary’s SELF Model applied to the Dialysis Unit Setting



they served. The National Child Traumatic Stress Network (NCTSN) developed a trauma-informed toolkit entitled “Medical Traumatic Stress Toolkit” for medical facilities that treat children. The aim of the Toolkit is to assist the medical team in dealing with the stress and loss associated with the medical traumas (NCTSN, 2004). Kassam-Adams et al., (2014) surveyed 200 pediatric nurses on their opinions and knowledge of trauma-informed care. The nurses reported that barriers to implementing trauma-informed care included time constraints, training, and worry about re-traumatizing patients. This study demonstrates the ongoing need for more research to better understand the implications of trauma-informed practices.

Although there is growing interest in incorporating trauma-informed models into healthcare settings, little research exists regarding the early childhood experiences of dialysis patients or the present traumatic experiences for this population. For patients who have experienced childhood traumas, the psychological pain of dialysis could result in more problematic behaviors, including medical non-compliance, and increased service utilization (Tagay, Kribben, Hohenstein, Mewes, & Senf, 2007). Tagay et al., (2007) report in a study of over 144 hemodialysis patients that almost 80% of participants reported having experienced at least 1 traumatic event. Of this 80%, only 10% of the reported traumatic events were associated with hemodialysis. Tagay et al., also found that patients with Post Traumatic Stress Disorder (PTSD) showed significant decreases in mental health, including depression, anxiety, and life satisfaction compared to patients reporting no PTSD symptoms. If individuals have healthy adaptive responses, encountering stress can produce resilience. However, if the stress or experience is unrelenting and chronic, which is often the case with long-term diseases, it can wear down the body and create difficulty regulating internal states and managing strong negative emotions, such as fear and shame (Duman, Malberg, Nakagawa, & D’Sa, 2000). Many trauma survivors manage strong affect with dissociative defenses by shutting off from emotional experiences and as a result engage in avoidant coping mechanisms that eventually trigger intrusive memories or flashbacks (Herman, 1997). Other survivors attempt to self-soothe through self-harming re-enactments of past trauma (Brown, 2006; Linehan, 1993). This re-enactment is often experienced as self-sabotaging behavior that frustrates service providers and translates into relationship difficulties (Bloom & Farranger, 2010). For service providers who are unaware of these dynamics, these relational patterns become assessed as lack of compliance, poor motivation, or ways to intentionally or unintentionally punish the provider. This may push the provider to become cold and punitive.

Regardless of whether or not adverse patient experiences result from past or present traumatic events, such events can lead to defensive responses that could have an impact on treatment outcomes and the environment in which treatment is provided (Davison, 2007; Dermody & Bennett, 2008; Kaveh & Kimmel, 2001; Kimmel, 2000). Despite little

evidence regarding trauma and the dialysis population, there is potentially significant value in developing a trauma-informed culture in the dialysis unit setting. The implementation of such a program could potentially improve patient outcomes, and reduce the overall risk of dialysis staff exhibiting symptoms of collective trauma similar to those of their patients. The following case example will help to further demonstrate the applicability of the Sanctuary Model in a dialysis unit setting.

### *Case Application*

The setting for this proposal is a 20-seat dialysis unit situated in a small rural town in Pennsylvania. The patient population served is predominately white, lower-to-middle class, aged 65 and older, with an increasing number of patients in their 80s who reside in a nursing home setting. The unit is staffed by registered nurses (RNs), licensed practical nurses (LPNs), and technicians, all of whom provide direct care to the patients. The leadership for the unit consists of one unit RN team leader, an operations manager, and a medical director. Additional staff members include three dietitians, one chaplain, a licensed social worker, a certified registered nurse practitioner (CRNP), three nephrologists, and a secretary. The dialysis unit is open daily, with the exception of Sundays from 6:00 a.m. to 4:00 p.m. On average, 70 patients receive treatment at this unit. The renal social worker would be responsible for introducing and implementing the SELF Model. [Table 1](#), column 3, further illustrates the issues and interventions addressed in each module of the SELF Model described below.

### *Identified Problems as They Relate to the SELF Model*

The dialysis unit setting as it relates to the SELF Model can be described as an environment that involves problems related to safety, emotional management, loss, and future. When patients and staff do not feel safe in this environment, present with difficulty managing emotions manifested from the environment, or struggle to cope with feelings related to loss, there is potential for poor outcomes including decreased staff and patient quality of life (Chan, Brooks, Erlich, Chow, & Suranyi, 2009; Jablonski, 2004). A clear understanding of how these problems manifest among staff and patients is valuable for renal social workers to effectively facilitate interventions and empower staff and patients to create a healthy and meaningful treatment experience.

**Safety.** Workplace stress as it relates to safety can be particularly paralyzing in the dialysis unit because staff are continuously faced with their own mortality when working with patients who have a terminal illness. Safety in this context is defined as feeling psychologically safe, as well as safety in relationships and in the environment (Bloom & Farranger, 2010). This means people can feel free to express their emotions and, in turn, have a predictable environment where they feel cared for. In dialysis units and in hospital settings, mortality and the associated feelings are often unexpressed and repressed. Unconsciously and consciously, this can lead

to staff feeling unsafe, which is likely to lead patients to feel unsafe. Therefore, it is important for staff to have space to express and work through their own emotions and express what is bothering them, to unearth disassociated emotions so that they are able engage in emotionally satisfying labor. When this happens, they will more likely create a well-regulated and emotionally attuned environment for patients and can tolerate and respond to the varying affective states that patients may express. This shifts the service from being crisis-driven into an empathic interaction that is satisfying to the staff and responsive to patients' needs. Specific concerns about safety in the case example are comprised of: a) a disconnect between staff and management that leads to decreased autonomy and low morale among staff; b) conscious fears about poor training programs and ill-prepared staff; and c) unconscious and conscious fears about personal mortality. Importantly, staff members from the case example often express feeling "silenced" by management regarding their concerns for safety.

The dialysis unit continues to experience a high turnover rate for registered nurses (RNs). RNs must be trained for six months before they can independently work with a patient and take on-call. Despite this six-month training process, some RNs have transferred to other positions, leaving the nurses who trained them feeling frustrated, overwhelmed, and betrayed. When good people leave an organization or stay unsupported and experience burnout, harm to the entire system is possible (Bride, 2007). In this case example, there is a generational gap that exists between senior nurses and newly hired nurses, resulting in a split among the staff that can be toxic for the patients. Issues regarding privacy make communication problems among the staff more complex. As with many dialysis units, this setting often does not allow for privacy among staff or patients. Furthermore, when conflict is present in the unit among staff or management, there are likely opportunities for patients to witness negative interactions among staff. When patients witness conflicts or arguments among staff in the dialysis unit setting, it is possible that safety concerns may arise or patients may develop issues of mistrust.

Although fears regarding personal mortality and illness are not openly discussed in the dialysis unit, they are unavoidable, given the nature of the work environment. Despite past high mortality rates in this unit case example, the system in place to address the death of patients or to provide support to staff when patients die is limited. Discussions surrounding loss and grief are not a priority or a part of the unit culture. Unfortunately, this approach can create an emotionally charged environment in which staff is unable to express loss, and as a result, often become detached and desensitized to patient suffering, pain, and death. This detachment has an impact on empathy and the ability of the staff to form healthy attuned relationships with the patients.

Furthermore, the employees are dependent upon systems that shape how they practice, often resulting in decreased satisfaction with work and a decreased sense of purpose.

This can create vulnerabilities for the helper and negatively disrupt how they derive meaning from their reality. Work that once gave satisfaction and meaning to the worker can become burdensome. This will invariably impact the treatment and empathic engagement with patients.

Staff perceptions regarding safety can mirror the experiences of dialysis patients. Issues including dependency, mortality, and loss of control can result in feelings of powerlessness and a decreased sense of self among staff and patients. Social workers can collaborate with management to address issues of safety to help improve the culture of the dialysis unit. Examples of how safety can be addressed in the SELF Model are found in [Table 1](#). One of the most important steps that social workers can take when introducing the SELF Model is to provide reassurance that training and workshops will be founded upon a collaborative approach that emphasizes safety. Additionally, social workers can work with management to reinforce the value of providing staff with the resources and training to promote an overall sense of respect and value among staff, management, and patients.

**Emotional management.** Emotional management in the dialysis unit setting has various implications for staff and patient well-being. When staff and patients do not effectively manage emotions, the outcomes can be both physically and emotionally damaging (Bremmer, 2003; Grandey, 2000). Dialysis staff who are emotionally attuned are more likely to be aware of the impact dialysis can have on individuals and their families, and as a result, should be better prepared to respond to a wide range of distressing emotions (Schore, 2003). This preparation can result in improved communication among staff, patients, and management. On the other hand, the following consequences can occur as a result of poor emotional management: a) staff burnout; b) reduced staff and patient satisfaction; c) compromised patient care; and d) a decrease in patient and staff quality of life (McQueen, 2004; Miller et al., 1995; St. Pierre et al., 2011).

Various physical and psychosocial factors may have an impact on how well dialysis patients manage their illness, including chronic pain and depression (Davison, Chambers, & Ferro, 2010). Although studies suggest that chronic pain in dialysis patients has an impact on both physical and mental health, pain and discomfort with dialysis treatment is often under-reported, poorly understood, and complex due to the multiple medications and comorbidities of dialysis patients (Davison et al., 2010; Davison, Koncicki, & Brennan, 2014). Dialysis treatment alone can result in significant changes for patients, including increased use of the healthcare system, changes in employment and level of independence, and potential challenges with intimate relationships with family and friends (Davison et al., 2010). Despite patients on dialysis having impaired health-related quality of life (HRQoL), renal providers are often unaware of patient symptoms and effective ways to reduce and treat symptoms in this population (Weisbord et al., 2007). This lack of understanding of the needs of this group may be associated with the degree

to which emotional symptoms affect patients' HRQoL (Weisbord et al., 2007). Furthermore, patients' emotional responses to dialysis or past traumas that are triggered by dialysis can make treatment more challenging for staff, particularly when they cannot adequately manage their own emotions relative to their patients (Kazak et al., 2006). When the dialysis staff is unable to manage their own emotions, they can create an environment filled with "emotional contagion," placing patients in an unhealthy and potentially controlling environment, of which they may try to avoid (Bloom, 1997, p. 42.). Organizing and making meaning from a distressing experience is critical to the recovery process of patients living with chronic illness (Seifter, 2010). This may mean that a healthy treatment environment would involve best practices for managing both patients and staff emotions as they relate to exposure to chronic illness.

Support programs that help staff and patients identify, understand, and manage their emotions could be very beneficial in dialysis units. Social workers can work with staff and management to develop training and workshops that aid staff in better understanding the role of staff and patient emotions in the dialysis unit setting. Specifically, workshops that focus on emotions related to fear, death and dying, loss and grief, and dependency will provide a good foundation for staff to understand how to manage personal and patient distress (See [Table 1.](#))

**Loss.** Loss, as it relates to dialysis patients and staff, can result in poor coping and decreased quality of life (Chan et al., 2009; Jablonski, 2004). In this dialysis unit case example, specific concerns about how loss is felt and handled include: a) loss as it relates to physical and emotional aspects of chronic illness; and b) loss as it relates to organizational change. Dialysis staff can witness profound loss with their patients, including amputations, loss of finances, loss of independence, loss of employment, and loss of life (Chan et al., 2009; Jablonski, 2004; Kimmel & Peterson, 2005). Although more information is needed to better understand aspects of loss with this population, current research suggests that loss caused by chronic illness can result in a grief response that can profoundly impact coping and lead to depression (Chan et al., 2009; Israel, 1986).

Dependency on dialysis alone can create tremendous feelings surrounding loss of control. This experience may trigger memories of resolved and unresolved trauma that manifest in poor coping skills that staff need to help patients navigate. Given this aspect of treatment, it is important for patients to not be subjected to an environment that reinforces this loss.

Dialysis unit personnel can become "emotionally anesthetized" as a result of experiencing traumatic losses of patients on a frequent basis (Bloom & Farragher, 2010, p. 181). This level of emotional desensitization could be particularly damaging and result in decreased support from staff. Although limited data exists regarding the degree to which staff social support improves outcomes in dialysis patients, studies have

demonstrated a link between social support from healthcare staff and patient quality of life (Patel, Peterson, & Kimmel, 2005; Untas et al., 2010). Dialysis staffs' level of exposure to loss is unique, and if not properly managed could result in emotional exhaustion, decreased job satisfaction, and disengagement from the staff-patient relationship (Maslach, 2003; O'Brien, 2010). It is critical to acknowledge and name losses, even when one is an expected part of prognosis. It acknowledges the dignity of the person and recognizes that losses can have a differentiated impact depending on context.

Dialysis unit staff may also experience loss when they are exposed to continuous changes, or an environment that is not perceived to be supportive or empowering (Hochwalder, 2007; Lachinger & Leiter, 2006; O'Brien, 2010). The difficulty that staff has accepting the changing climate of the healthcare industry may mirror the difficulty that many patients experience when faced with changes related to their illness.

It is not uncommon for dialysis patients to exercise their will in a self-deprecating manner when they are confronted with loss (Chan et al., 2009; Witenberg et al., 1983). Many patients may experience a false sense of satisfaction and control even when they make poor decisions about their health; for example, they may eat the wrong things, drink too much liquid, or make a conscious choice to not take medication (Chan et al., 2009).

Similarly, dialysis staff may react to environmental changes and constraints with resistance or resentment. This coping response can develop when loss of autonomy is experienced with regards to decision-making within the unit. However, when staff perceive they have control over the environment and believe that their values align with that of the organization, they are more likely to experience psychological empowerment (O'Brien, 2010; Rappaport, 1987; Spreitzer, 1995). Resistance to change by both staff and patients often results from a fear of losing the past and giving up what is comfortable, even when it is unhealthy (Bloom & Farragher, 2010). For staff and patients alike, accepting change can be one of the most difficult challenges to overcome.

Support programs, focused on fear and conflict as essential parts of the growth process, can help individuals approach loss in a healthy and productive manner. Social workers can collaborate with staff and management to create a dialysis unit culture that embodies psychological empowerment. This focus helps clients and staff recognize the importance of self-determination and interdependence. Self-determination and interdependence are core components of social work training and practice, and play key roles in positively changing the dialysis unit setting (Council on Social Work Education, 2008; Gutierrez, Glenmaye, & DeLois, 1992, Gutierrez, Glenmaye, & DeLois, 1995; ). Suggestions for how to begin to facilitate workshops focused on loss are found in [Table 1.](#)

**Future.** The future as it relates to the dialysis unit setting is filled with fear, excitement, and hope. Staff and management need to embrace change within the healthcare delivery system. In addition to a highly demanding and growing dialysis population, there will be even larger systemic changes within the healthcare industry and society that will significantly affect how care is provided and received (USRDS, 2014). Limited resources, greater demand, and higher expectations of service will make for significant potential challenges (Hawkins, Shohet, Ryde, & Wilmont, 2012). Characteristics of helping professionals, such as those who engage in dialysis work, include feelings of satisfaction from helping others cope and heal (O'Brien, 2010; Sabo, 2011). However, when organizational optimism is not nurtured, and professional development is not encouraged or supported, helping professionals' satisfaction levels can decline (Kouzes & Posner, 2012; O'Brien, 2010). It is important to nurture organizational optimism by conquering present issues with an eye on future challenges and changes in order to attain long-term sustainable goals in health service organizations. The future success of the dialysis unit presented will depend greatly upon awareness, healing, and professional growth among staff and leadership, and will be measured by the level of staff satisfaction and patient outcomes.

Through education and support, social workers help institutions change (Cummins, Byers, & Pedrick, 2011; Netting, McMurtry, Thomas, & Kettner, 2011). Targeted efforts enable social workers to empower clients and deter the impact of hopelessness on clients' sense of self and their relationships. In the same vein, social workers can empower organizations to address past, present, and future barriers to cultivate an environment that is responsive and dynamic. Furthermore, the profession is action oriented and grounded in efforts to make changes at all levels of practice (Cummins et al., 2011; Netting et al., 2011). This approach to change is particularly important in the dialysis unit setting, where resistance to change among staff could potentially result in decreased quality of care and poor job satisfaction (Huber, 1995). Social workers can develop workshops with management and staff that focus on promoting acceptance of change and emphasizing understanding, psychological empowerment, and sustainability. Suggestions for potential workshops are listed in [Table 1](#).

The following is a brief proposed implementation plan for the SELF Model (See [Table 1](#).) designed for the case example. This proposal can be used as a guide for other units to consider when utilizing Bloom and Farragher's (2010) Sanctuary Model, of which SELF is a component.

## IMPLEMENTATION PLAN

### *Phase 1*

Upon receiving support from senior leadership of the organization, a module for each specific area of SELF will be developed in collaboration with the regional governing body for the dialysis unit (in this case Network 4) and the

dialysis unit staff. The unit social worker will then organize and facilitate each module. The first stage in this phase will involve a community meeting among staff and management to cultivate safety and trust. During this process, expectations and goals will be clearly defined to help create a predictable and safe environment. The social worker will hold an educational in-service for staff and management on trauma and stress in the dialysis unit setting, with a specific focus on the value of understanding how emotional labor affects the body and the mind, and ultimately, patient outcomes. Additionally, staff will be matched with one of the four following modules: Safety, Emotions, Loss, and Future found in [Table 1](#).

**Timeline:** All four modules will be completed quarterly over the course of a year. Each specific module will run for four weeks, during which time staff assigned to the module will present a weekly in-service.

## OUTCOMES AND MEASURES

For each SELF-Module, the staff will design a questionnaire to address competency, knowledge base, and overall level of staff satisfaction to determine effectiveness of the program and address future needs of patients and staff. Staff will receive questionnaires pre- and post-module. Additionally, the unit social worker will provide the staff with the Professional Quality of Life Scale (ProQOL) prior to the start of the modules and after the final module is completed (Stamm, 2010). Additional outcomes measures addressing patient quality of life, psychological empowerment, life stress, and conditions for work effectiveness will be considered.

### *Phase 2*

Staff and patient satisfaction surveys, along with other identified appropriate measurements, will be distributed and reviewed yearly to identify areas needing improvement and support. The dialysis staff will be annually assigned new modules that will focus on all 4 areas of SELF and will be responsive to contextual changes in the unit and in practice to ensure diversity of learning in the workplace.

## CONCLUSION

Bloom and Farragher's (2010) SELF Model provides a framework within which dialysis units can begin to develop unit-specific designs that foster a healthier working environment. Dialysis unit social workers are in a unique position to champion and assist implementation of such programs. The changing dialysis environment, including the increasing needs of dialysis patients coupled with a reported nursing shortage and an increase in burnout, signifies a call for greater attention to the needs of the staff (Gardner, Thomas-Hawkins, Fogg, & Latham 2007). Emotional labor that involves work overload, death and dying, uncooperative patients and family members, and high job demands can have a poor impact on nurses' stress levels (Lambert & Lambert, 2001). However, with the proper tools and guid-



**Table 1.** SELF-Modules and Objectives

Module	Workshop and Objectives
<b>Safety Module</b>	<ul style="list-style-type: none"> <li>• Define what safety means to you personally</li> <li>• Define the different types of safety (physical, psychological, social, and moral)</li> <li>• Define safety as it relates to patients and devise a plan to ensure optimum physical and emotional safety of patients</li> <li>• Identify the importance of boundary making in the dialysis unit setting and how appropriate boundaries improve staff and patient outcomes</li> <li>• Identify manageable change that can result in a safer working environment for staff and patients</li> </ul>
<b>Emotions Module</b>	<ul style="list-style-type: none"> <li>• The basics of understanding emotions for staff and patients</li> <li>• The emotional impact of fear as it relates to death and dying</li> <li>• The role of emotional intelligence in the dialysis unit</li> <li>• How chaos in the dialysis unit can be emotionally paralyzing</li> </ul>
<b>Loss Module</b>	<ul style="list-style-type: none"> <li>• Defining loss as it relates to self</li> <li>• Defining loss as it relates to dialysis patients</li> <li>• Recognizing the value of self-determination</li> <li>• Understanding the role of loss in personal growth and organizational change</li> </ul>
<b>Future Module</b>	<ul style="list-style-type: none"> <li>• The value of understanding the past in order to move toward a healthier future</li> <li>• How power is perceived and utilized by staff and patients</li> <li>• How to prevent becoming learning-disabled organization</li> <li>• Preventing self-fulfilling prophecies and traumatic reenactment</li> <li>• Breaking away from non-adherence and embracing cultural change and sustainability</li> <li>• Working toward an organization that promotes psychological empowerment</li> </ul>

ance, these complex aspects of care can be managed in a sustainable and healthy environment in which staff and patients experience high levels of satisfaction. Frontline or direct care practitioners find meaning and satisfaction in their work and have less resilience when they have adequate training, coping strategies, and supportive work environments (Bride, 2007; Craig & Sprang, 2010; O'Brien, 2010). Adequate training allows them to have a specialized understanding of their patients' needs, including emotional regulation. Improved coping strategies equip them to detect, monitor, and treat their own work-related stress and creates a supportive work environment that communicates that the organization is invested in the well-being of the staff as opposed to reactions to ongoing crises.

Trauma-informed support programs designed to help dialysis staff effectively manage the challenges of this high-stress environment are valuable, and can be facilitated by Master's-level renal social workers. Social workers are trained to be change agents at all levels of practice and understand the interconnectedness of micro- and macro-environments

(Netting et al., 2011). This is especially important in the dialysis unit setting, where organizational stress can result from poor preparation to cope with overexposure to traumatic incidents. Furthermore, trauma-informed interventions aimed at improving outcomes for clients and organizations are growing in social work practice and education (Breckenridge & James, 2010).

This proposal provides the design for renal social workers to develop an on-site trauma-informed program that fits the needs of their dialysis unit setting. The authors recognize that renal social workers have extensive job responsibilities and may not have the time to devote to comprehensive staff interventions. However, there are many aspects of the SELF Model that can be applied in smaller increments over longer periods of time, making application of this model more feasible. Additionally, renal social workers can assume the roles of facilitators and leaders through introducing innovative interventions that have the potential to improve outcomes for patients and staff. Further research in this area addressing the effects of this model on staff and patient quality of life

is warranted. The proposed module in this manuscript will be introduced and implemented in 2016 in a dialysis unit known to one of the authors. Measured outcomes for the proposal will include professional quality of life (including compassion satisfaction, compassion fatigue, and burnout), patient quality of life, psychological empowerment, and conditions for work effectiveness. There is compelling information that suggests that trauma-informed staff interventions in dialysis unit settings could positively impact professional quality of life and patient outcomes. Further attention to this area of practice is needed to best understand feasibility and acceptability of such interventions by renal social workers.

#### AUTHOR NOTE

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