Evaluating *Adjustment to Health Condition* and *Adjustment to Hospitalisation* as Indicators for Intervention.

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Abstract: This article describes an exploratory study aimed at elucidating social workers' understandings of the concepts of *Adjustment to Health Condition* and *Adjustment to Hospitalisation* as *Indicators for Intervention*. Thematic analysis was utilised on data from in-depth semi-structured interviews and focus groups with eighteen experienced health-care social workers. The findings demonstrated that *adjustment* was conceptualised as a complex, multi-dimensional process including the key inter-related themes of *coping*, *emotion*, *subjective meaning*, *adaptation*, *support*, *family-focus*, and *process orientation*. The findings can assist social workers in conceptualising their practice and articulating their role with clients and with other health professionals in relation to crucial *adjustment* issues identified in health care settings. Implications for social work education and outcomes measurement development are discussed.

Clear 'problem' definition forms the foundation of appropriate and effective intervention strategy selection within clinical health social work practice. It also forms the basis for clinical evaluation and the development of outcome measurement.

In Australia, the National Allied Health Casemix Committee (NAHCC) was formed in 1991 as a peak body representing fourteen allied health professions on classification, outcomes reporting and health funding. In 1994 the NAHCC was funded by the federal government to develop a nationally agreed framework of data items and definitions to be collected by health professions (Cleak, 2002). The NAHCC undertook to develop a patient centred allied health classification model that could provide an integrated approach to reporting of inputs, processes, outputs and outcomes within the health-care system (Woodruff, Fitzgerald & Itsiopoulous, 1999). An integral component of the NAHCC model has been the development of *Indicators for Intervention* (IFIs). IFIs have been defined as: "A service provider description of the characteristics of the individual or population which indicate need for intervention" (Woodruff et al, 1999; p.27). IFIs were developed in a four level hierarchy. Of the categories within the primary level, [(1) *Psychosocial factors*, (2) *Sensorimotor and Biomechanical functions*, (3) *Cardio-respiratory function*, (4) *Nutritional factors*, and (5) *Social/Occupation and Environment factor*s] the IFIs most relevant to social workers are clustered within the two categories of *Psychosocial factors*, and *Social/Occupation and Environment factors*.

The NAHCC IFI codes are available to health organisations for use within their data coding systems. Allied health practitioners can use them to classify the reasons for their involvement with clients. Statistics on professional activities also often include information about time spent on tasks and sometimes record which particular interventions have been undertaken. At this stage the PIs have not been developed but it is envisaged that they could be utilized for a range of purposes including research and quality improvement activities, or within funding models and service agreements.

In a study of coding practices utilising this IFI framework for categorising referral 'problems' by social workers at a paediatric hospital (Nilsson & Fitzgerald, 2001), it was found that 41% of referrals were primarily related to *adjustment* issues [*Adjustment* is a sub-category within *Psychosocial Factors* and includes the five tertiary level sub-categories: (1) *Adjustment to Health Condition*; (2) *Adjustment to Hospitalisation*; (3) *Bereavement/Death*; (4) *Victim of Violence*; and (5) *Phase of Life Problem*]. When including secondary and tertiary reasons for referral this figure rose to approximately 53% of total referrals (Nilsson & Fitzgerald, 2001). In the same study it was found that two of these IFIs, *Adjustment to Health Condition* and *Adjustment to Hospitalisation*, together accounted for 47% of all IFI codes used to describe the reasons for intervention. These preliminary analyses demonstrated the significance of the IFI *Adjustment* for social workers in paediatric health-care settings.

The NAHCC have defined the concept of *Adjustment* as, "Disorders where the focus is on the individual's inability to manage life events or changed circumstances" (Woodruff et al 1999, p.76). This definition however, with its focus upon 'disorders', may not fit comfortably with social workers' conceptual understandings of their practice in health care settings. It is also possible that this construct could be variously interpreted, both within the social work profession and also between allied health professions, due to an apparent lack of clear conceptualisation and appropriate definitions. Furthermore, the NAHCC have not as yet provided definitions for the more specific concepts of *Adjustment to Health Condition* and *Adjustment to Hospitalisation*. As a result, the validity and reliability for this IFI category may be compromised within the NAHCC model.

A study was undertaken to ascertain the meanings of *adjustment* IFIs for social work practitioners in health-care (Nilsson, 2002). Guiding questions included: (1) How do social work practitioners in health care settings conceptualise the NAHCC IFIs *Adjustment to Health Condition* and *Adjustment to Hospitalisation*? ; (2) Are *Adjustment to Health Condition* and *Adjustment to Hospitalisation* conceptualised in a mutually exclusive manner as is required within Australian Commonwealth guidelines for coding systems? ; (3) Are *Adjustment to Health Condition* and *Adjustment to Hospitalisation* each conceptualised in a consistent manner by professionals from different types of health-care settings (ie paediatric versus adult acute care)? ; (4) Is there common agreement between social workers as to the meanings of *Adjustment to Health Condition* and *Adjustment to Hospitalisation*? ; (5) Which clients or client groups form the focus for *adjustment* related interventions?

While there are a broad range of theories that inform social work practice in health care, there is no specific research on the conceptualisation of *Adjustment to Health Condition* or *Adjustment to Hospitalisation* per se. Therefore the second aim of this study was to explore what theory, or theories, inform social work practice in relation to these IFIs and if there was a need for theory building.

Study Design

This exploratory research study utilised a predominantly qualitative methodology that incorporated semi-structured interviews and focus group discussions, supported by some descriptive quantitative analyses. The study was initially informed by a grounded theory approach (Glaser & Strauss, 1967) in order to avoid any preconceived notions about how *adjustment* is conceptualised and to facilitate the flexible interaction of data and theory (Neuman, 2000, p.146). However, the objective of pure theory-building through an inductive approach was expanded to incorporate an element of theory-testing and redevelopment after initial data analysis revealed that an existing body of knowledge appeared to have particular relevance to the research topic.

Participants

Purposive sampling was used to recruit eighteen social workers from two acute health-care settings in Melbourne, Australia, one an adult setting (n=9) and the other, paediatric (n=9). Only social workers

with more than twelve months professional health related experience were invited to participate to ensure sufficient relevant professional practice experience to reflect upon. Participants encompassed a combined 174 years of social work experience (mean of 9.9 years; median of 8.5 years). As Mental Health/Psychiatry services do not use IFI coding, social workers from these programs were not invited to participate.

Organisational Contexts of the Research Settings

The paediatric hospital employs 1740 Full-time Equivalent (FTE) staff providing approximately 30,000 admitted patient services per annum. It provides state-wide, national, and international services incorporating a broad range of clinical, academic and advocacy services for children and young people, covering almost a quarter of all patient separations for 0-19 year olds (excluding normal newborn babies) for the state of Victoria. The social work department employs 14.6 (FTE) staff to provide social work services to the hospital's thirty-two primary medical and surgical units.

The adult acute-care hospital provides a comprehensive range of specialist medical and surgical services for adults through 42 clinical units, offering every form of medical treatment with the exception of obstetrics and paediatrics. It has a staff of 3500 and treats more than one quarter of a million patients annually with 22.5 (FTE) social work staff employed to provide services through all clinical units.

Both hospitals have a commitment to the NAHCC work on classification and measurement models and have previously served as research sites for the initial testing of the NAHCC IFI model.

Data Collection Processes

Phase One: Semi-structured Interviews

Primary data was collected through individual in-depth semi-structured interviews using a standardised format which allowed for follow-up questions to clarify specific issues of relevance. Interviews were audio taped and copies of the transcripts were offered to participants. After collecting background demographic information, participants were asked to recall a case where they had, or could have, ascribed each of the target IFI codes and to describe the aspects of the case that would have led them to

make that choice. They were also asked to identify any theories or bodies of knowledge that they believed to be related to these IFIs and whether they conceptualised the IFIs as being mutually exclusive. Participants were lastly asked to reflect on the relative importance of these IFIs to their work. The interview schedule was piloted with two social workers. No modifications were found necessary and the data from those interviews were included into the study.

Phase Two: Focus Groups

In the second data-collection phase findings from phase one were presented to participants for discussion within separate focus groups at each research site. Discussion was facilitated with a semi-structured series of questions. Participants were invited to comment on the preliminary findings specifically in terms of what they agreed with or disagreed with, and what they found 'surprising' or 'of concern'. Participants were also encouraged to identify where findings did or did not concur with their personal experience of *adjustment* related practice. Focus group participants were also invited to comment on the potential efficacy of a selected theoretical framework to explicate the conceptualisation of *adjustment* for social workers in health care.

Phase Three: Exploratory Survey

A small-scale exploratory quantitative survey aimed at exploring the intended focus of *adjustment* related interventions was conducted at the paediatric hospital on five differing weekdays over a five-week period. All social workers working on the designated survey days were asked to record all *adjustment* related intervention activities on a standardised survey sheet including: (1) which person(s) they actually communicated with in relation to these *adjustment* cases; and (2) the person(s) who formed the focus of that communication.

Data Analysis

Qualitative data was thematically analysed in three stages to determine theoretically important and meaningful categories or units that related to the central questions of the study (Sarantakos, 1998). Initial reading of interview transcripts was aimed at identifying critical terms or themes (by frequency of occurrence or by the significance attributed to them by individual respondents) and compiling these into a list of thematic categories. A second full reading occurred a week later in order to further

examine, reflect on, and review this initial list of concepts/themes and identify any linkages. Where themes were identified as having strong linkages, or where closer analysis revealed them to be analogous concepts, they were grouped together. The initial list of themes was then further refined into related categories. The final review of data, two weeks later, aimed to identify the over-riding theme for each category, to ensure that categories were as mutually exclusive as possible, and to ensure that no critical themes had been overlooked. The quantitative data was analysed by use of basic descriptive statistics (eg. means and medians).

Findings

This study found that *Adjustment to Health Condition* and *Adjustment to Hospitalisation* were both highly important to social work practice in health-care. On a scale of one to ten (with one being 'least important' and ten being 'most important'), the mean rating given by study participants for the importance of *Adjustment to Health Condition* to describing their professional practice was 8.54 (*n* =13). The mean percentage of cases that were estimated to involve this concept was 72 % (*n* =11). The equivalent mean 'importance' rating for *Adjustment to Hospitalisation* was 7.36 (*n* =16), and the mean percentage of estimated cases relating to this concept was 57 % (*n* =13). [1] It therefore can be concluded that while *Adjustment to Health Condition* is used more frequently as an IFI than is *Adjustment to Hospitalisation*, both concepts are perceived to be of similar importance for describing the reasons for intervention by social workers.

While the findings reveal congruence between many of the identified sub-themes, there did not appear to be consensus on a unitary definition for either of these concepts. Several participants commented on the lack of clarity they experienced in relation to these concepts and their desire for adequate definitions to be developed:

> *I think I've recognised how incredibly complicated both concepts are and that there's a long way to go to try and work out how is the best way of defining it, if you can. …They are almost*

[1] The n value varies for each result as some of the eighteen respondents were unwilling to provide a numerical value for particular categories.

> *like terms that are so commonly used, you forget what the real meanings are, and the complexity of the meanings* [11]. [2]

A lack of clarity for respondents in regard to the over-arching concept of *Adjustment* was also revealed through the interview process. Many respondents also noted that these terms constitute professional jargon that they would not use within client interactions:

> *You ask that question of a patient, 'Do you think that you are adjusting to your hospitalisation?' and they would look at you as if you are a lunatic* [17].

In practice, social workers appear to approach the issue of *adjustment* in a more indirect manner by instead asking general questions such as, *"How are you going?"* or *"How are you dealing with being here?"* or *"How has it been for you?"*

An important over-riding theme throughout the interviews was the need to understand *adjustment* as being a *process* that is "fluid", "dynamic" and "ongoing". Indeed, many social workers expressed concerns that the terminology infers that a final state of *adjustment* could, or should, be achieved as an outcome of intervention:

> *I'm not sure that there is an 'adjusted' and 'not adjusted'. I'm not sure it's that clear cut. I think there is a process of adjustment…It should be 'adjusting' to health conditions* [6].

Many social workers emphasised that *adjustment* may have varying phases or stages that are sub-components but that these need to be viewed as part of the larger ongoing *adjustment* process:

> *I think adjustment is more about a process, although I mean people have different phases of coping over time. I suppose adjustment takes place over a longer period of time in the families that I am working with* [11].

Key Sub-Themes

Adjustment to Health Condition and *Adjustment to Hospitalisation* were both shown to be understood as multi-dimensional concepts with respondents at both the paediatric and adult health care settings identifying the same range of sub-themes. In general participants described a very similar conceptualisation of *adjustment* processes and no single interview stood out as presenting a radically different viewpoint. All participants included the concepts of *coping* (or *managing*), *emotions*,

[2] All quotations from participants are referenced by the code number in brackets.

subjective meaning, *adaptation* (or *integration*) and *support* within their discussion. Most participants also identified a very similar range of theories as underpinning this concept including those of *systems* or *ecological theory*, *grief and loss*, *crisis theory*, and *support theory*.

Coping

Coping was the most common term used in describing the process of *adjustment*:

> *…how that family at that time were coping in terms of things like coping with how they were managing the rest of their lives, which might be things about their work life, things about siblings, those sorts of things – in terms of coping about how they were taking in the medical information and what they were understanding, and in terms of how they are then being able to make some decision about that* [5].

Another term that was often used in conjunction with, or as an alternative to, *coping* was *managing*. Social workers often spoke of *adjustment* in terms of the ability to *manage* a given situation:

> *…the goal is around helping them get through it basically, to manage it* [7].
>
> *…the kinds of issues that were coming up were that it was…very challenging physically, psychologically, spiritually, vocationally, etc for families to manage with any sort of sense of their life being as they would either want it to be, or it has been, or as it normally was or is; …very disruptive to what would either be usual for that family, or anticipated for that family. So, beyond their usual experience and beyond the kind of norm of the community* [4].

The previous quote also demonstrates that *managing* or *coping* in the health-care context is commonly deemed by social workers to relate to situations of change, particularly those involving circumstances out of usual life experience (i.e. extraordinary) that then constitute a crisis:

> *We get referrals from within the hospital regarding people's ability to cope, often associated with the diagnosis…Someone who's been newly diagnosed goes through a significant process of change; their lives undergo significant change and that requires adjustment, or a process of adjustment, in coming to terms with the implications of the diagnosis* [14].

The *adjustment* process was also reported to be linked to the stated concept of *equilibrium* in that the *adjustment* process is purportedly aimed at ameliorating the crisis in order for the individual or family to return to a 'normal' state:

> *It is a crisis and I think most families at some stage return to some equilibrium, some sort of way of maybe adjusting or getting through* [7].

When asked how they assessed coping, all participants appeared to struggle with articulating any specific process or framework:

> *I think I probably started off thinking 'yes', we did have a means of really assessing what that is and whether a family is coping or not coping, but I think that over time I have found that to be a very difficult task. I always wonder what we are assessing* [1].

Analysis of interview transcripts also revealed an apparent contradiction in that whilst many social workers utilised the word *coping* within their descriptions of *Adjustment to Health Condition* and *Adjustment to Hospitalisation*, many of the same people also articulated strong concerns about using the word *coping* as a general descriptor for *adjustment*, believing that this term has negative implications or connotations:

> *I hate the word 'coping'…because I just think that it is so loaded and so judgemental…I don't like it because what it says is – there is some kind of line, it's like the 50% line, and above 50% you cope; 49% you don't…I think what it does is it kind of squeezes people into some sort of little, narrow, itty-bitty definition of what it is to be normal (within) some sort of abnormal situation…I think it's harsh* [4].

Indeed, many respondents expressed concerns about the potential for *labelling* of clients through the use of particular terms. It was noted that within a medical environment terminology is utilised in very specific ways and often focuses on pathological elements or deficits. One respondent stated that for her, *coping* only related to the more extreme 'crisis phase' of the adjustment process:

> *…coping for me is about survival and I suppose I talk more about coping in intensive care, where families just keep their heads above water; just survive* [11].

Other respondents also noted *survival* as an important task of *adjustment* in extreme circumstances:

> *Most times they are just in survival mode, so how can we get through this and come out of it pretty reasonable* [6].

Many social workers noted that information provision is one crucial form of intervention often used to assist *coping*. This sometimes takes the form of anticipatory guidance:

> *…they are often wanting someone to foreshadow what might be some of the issues. What might we expect, or how do other families manage this?…How do we get through this?…I guess some of our work is to try to prepare people…for things that might come up* [4].

Another intervention commonly described by respondents was that of facilitating communication, often in relation to debriefing from stressful situations:

> *…that they are communicating sometimes as a couple, that they are able to have space, and that's often what social work provides, space to debrief around the trauma of the diagnosis* [7].

Indeed, the concept of *trauma* was mentioned by several respondents as having a particular relationship to *coping* in the health-care context.

Adaptation

Thematic analysis also revealed common use of the words *adaptation, integration* and *impact* within the descriptions of *adjustment*. While these words all appear to have been utilised with different nuances, they may have a common link to the theme of *coping/managing* in that they all relate to the client(s) capacity to cope with the resultant effects of change events. Even though *impact* may relate to flow-on effects of a practical nature, ultimately these practical issues also have personal ramifications that relate to coping. The role of *impact* within *adjustment* was noted to relate not just to the current situation but also to future orientation. The anticipation of possible future ramifications for the client(s) was described as an important aspect of *adjustment* that may serve as an indicator for professional intervention.

Many respondents noted that *adjustment* requires a process of *integration* for the client(s):

It takes time to adjust, to integrate something. It's like a parent with a child dying, you never fully integrate it. You just get used to the idea… people don't ever adjust to it, they just get used to the idea, or integrate it in some way so that life is bearable [9].

Some respondents also linked the term *integration* to *adaptation* but expressed a preference for *adaptation*:

I use adaptation as opposed to adjustment…Adaptation is more of a positive frame, that we adapt to all sorts of things. So adaptation is a natural human response…So you may say that someone is having difficulties adapting to this or that, as opposed to having adjustment difficulties which tends to make a negative of what is a natural process [10].

Emotions

Emotional reactions and responses were frequently identified as key factors within the *adjustment* process. For example, in describing how families respond to diagnosis in a paediatric oncology unit one respondent noted,*"…some of the themes of reactions, things like shock, perhaps denial, disbelief, anger, guilt – those types of things; emotional reactions"* [1].

Respondents identified that not only are there a wide range of types of emotions associated with *adjustment*, but that these also range in strength:

…adjustment may take any number of forms from severe distress to mild discomfort… and that people's ways of dealing with it would be quite different. [14]

Two emotions mentioned with high frequency were *distress* and *anxiety*:

…people are very distressed and concerned…often families are not saying, 'Can I see the social worker?', …it's because …the family are distressed, they are really having trouble dealing with what's going on emotionally [11].

It was not the mother's request. I think it was more the considered opinion of the O.T. that this family was more anxious than the usual family [9].

These particular quotes highlight that when anxiety and distress are involved, these clients are not often self-referred to social work. This may be due to lack of self-awareness or because the individual(s) do not define such emotions as a 'problem', but rather it may relate more to how these emotions impact on others (including health-care professionals). Most commonly such situations are therefore either

identified by other health-care professionals or directly by the social worker in the course of the assessment process.

The previous quote also demonstrates that within *adjustment* related cases it is the relative severity of emotion that is assessed. 'Maladjustment' is deemed to be indicated where the emotional response is above and beyond that commonly expected for the given circumstances.

Respondents identified that an initial step in intervening in such cases is often to facilitate expression of the client(s) emotions and/or to assist in containing the emotional expression within 'safe' boundaries:

> *…it's really about creating that space for that expression…so not only stating, but also expressing the various feelings and emotions, and I think for social work that is a large part of our role; being a voice to that experience* [1].

Subjective Meaning

Another key theme identified was the role of *meaning*. Respondents often spoke of the need to comprehend clients' *subjective meaning* of their experience in order to effectively assess *adjustment*.

> *…you actually consider what is happening for the person medically; both the objective reality and the subjective reality of it* [12].
>
> *It is not actually often the illness itself, but it might be what it means to them…it doesn't necessarily mean if it's a serious illness that a parent will have difficulty coping with that because often parents are marvellous and very resilient even when a child has a very, very serious illness, and vice versa* [3].

Respondents noted that an important intervention is to explore client(s) subjective understanding of a given situation. In the process social workers may assist the client(s) to clarify problematic *adjustment* issues and to 'normalise' their responses:

> *I help people clarify their situation and they usually cope through that…So I talk more about clarifying and building awareness into what people think, not giving them coping skills* [9].

It was also noted that a dilemma in objectively assessing clients' subjective views is that social workers own beliefs or biases may impact on their professional interpretation of the situation and that this needs

to be guarded against. Indeed, it was noted that even between health-care professionals there may be disagreement as to what constitutes 'good adjustment'. The issue of subjectivity was generally viewed by respondents as being integral to the overarching concept of *adjustment* and that social work service needs to strive for individually tailored solutions that acknowledge the individual circumstances and subjective reality for the client(s).

Associated with this theme of 'subjectivity' were the respondents' perceptions that other professional groups may have different understandings of the need for intervention around *adjustment*. Respondents' comments about these differing understandings provide further insights into how these social workers conceptualise *adjustment*. Participants particularly noted that sometimes other health professionals appear to refer clients precipitously:

> *…talk to the nursing staff about their observations of that family…Often, sometimes, they are not accurate in their assessment…Sometimes a family will be extraordinarily distressed and upset and the nursing staff are, 'Oh my god, quick get the social worker', I come down and have a chat to the family and this is the way that they are dealing with it, in the best way that they can and they feel that they are able to (adequately) support each other; they don't want my involvement* [11].

As this previous quote suggests, many social workers appear to believe that assessment of these situations needs to include a judgement about whether intervention is desired by the client(s) and whether it can actually make a functional difference. Indeed, some social workers hypothesised that the haste of referral by other health professionals may relate more to the emotions engendered in them by observing the difficult *adjustment* processes of the hospital client(s):

> *…sometimes staff might become quite anxious themselves and might not know how to manage or deal with that situation* [1].

Another respondent noted that there may also be a functional component involved in that some other health professional groups may choose to detach themselves from the emotional aspects of the work in order to maintain focus on the physical care needs. The emotional aspects are therefore sometimes delegated to social workers for assessment and intervention.

Support

Respondents often commented on the important role that social support provision plays within health-care social work practice. Identifying and working with the client(s) support network was described as an important aspect of this role:

> *So I probably see my role as supporting them through; Part of it is also checking out what their network's like; who is around to support them* [6].

Indeed, it was particularly remarkable within the data that many of the descriptions of professional practice relating to *adjustment* focused more broadly on the client(s) significant support networks (most often defined as family) rather than solely on the individual patient/client him/herself:

> *I think that adjustment to hospitalisation and adjustment to illness is underpinned very much by our family systems approach. I mean, you are looking at a family within their context, within their environment; that's what you are trying to connect them with. They are not a person sitting in isolation, having no connections to anyone else.* [11].

However there were also sometimes more practical reasons noted:

> *I have to say, in intensive care, most of the patients that I would see are unconscious, so we are really dealing with their families* [11].

Integration of concepts in practice

While the themes identified by respondents as relating to *adjustment* have thus far predominantly been artificially separated out for the purposes of discussion, it must be recognised that they were described within the interviews, and are in actual practice, integrally related. The interview texts commonly included rich, thick descriptions identifying multiple themes within a single sentence or paragraph. For example:

> *I guess in the concept of adjustment to health condition, I'd be looking at what the meanings are for families around…the emotional adjustment, the meaning of that health condition and the impact it will have on the family in the immediate term and in the long-term, and the grief. So in terms of the emotional content, the grieving around that, and then there are also aspects around the practical issues…I guess I see it as a longer-term issue as well; that it's not adjusting not only to all the interactions in hospital and the in-patient stays…but also*

> *adjusting to what life is like in the community with a child that has a health condition and what impact that has on the family's dynamics, and what impact that has with the relating with other people in the community, what impact that has on the family financially and what impact that has on the family in terms of just their daily living* [5].

This statement highlights the inter-relationship between the multiple themes of *meaning*, *emotional adjustment*, immediate and longer-term *impact*, *practical* issues, *family* relationships, and *community* relationships. Examples such as this demonstrated the multi-dimensional nature of adjustment and the potential dangers of utilising a reductionist approach for analysis. Given the fundamental inter-relationships that have been identified between many of the sub-themes, it is apparent that an holistic or ecological approach to analysis may be preferable.

Exploratory Survey

The total number of *adjustment* cases reported within the five day exploratory survey was 297 but 10 cases were excluded due to incomplete data leaving a total of 287 (mean average of 53.2 *adjustment* related cases per survey day or 5.91 per worker given an average of nine workers on each survey day).

In relation to who was identified as the recipient of the *adjustment* related intervention, verbal or written contact was made predominantly with the patient's parents (mothers proportionately twice more than fathers) and with other hospital staff. In only 21.4% of cases was contact made directly with the patient - not an unexpected result in a paediatric hospital where over fifty percent of social work cases relate to patients under the age of five years.

In accordance with the qualitative data, results regarding the intended focus of interventions demonstrated a much broader 'family' focused approach with multiple members of the patient's family being the target of interventions in relation to *adjustment* issues.

Theories

When asked to identify which theory or theories or 'bodies of knowledge' they believe inform the concepts of *Adjustment to Health Condition* and *Adjustment to Hospitalisation*, most respondents named a broad range of theories:

> *With adjustment to health condition…the sorts of things that come to mind would certainly be around crisis theory, around loss and grief, around development* [4].

Ecological and systems theories featured predominantly as did trauma theory and the associated theories of crisis, and grief and loss. The diversity of theories identified also included psychoanalytical and phenomenological approaches.

It was particularly notable however that no respondent advanced a unitary explanatory theory for *adjustment*. There appeared to be a more eclectic approach to the application of theory in explaining this important practice concept. It was also notable that six of the eighteen respondents expressed reservations about answering interview questions related to theoretical underpinnings of professional practice and two were unable to identify any specific theories.

Several of the respondents who did identify a range of theories, appeared to do so in a cursory manner, often claiming to be 'eclectic' in their approach. The researcher was unclear as to whether the cursory nature of these responses reflected a lack of in-depth understanding of the identified theories and their potential applications to professional practice, or was simply an artefact of the interview process. The overall impression gained from the interview process however was that the respondents in general were not at ease or proficient at articulating their knowledge of the relationship between theory and practice in relation to *adjustment* issues.

While able to identify that the range of sub-concepts were indeed inter-related, participants could not identify any unifying explanatory meta-theory. This posed a conundrum as an integrative theory *appeared* necessary to explain these critical inter-relationships. Many respondents struggled to even provide a definition of *adjustment* in spite of its apparent significance to their work.

The author has subsequently postulated that the theory of 'emotional coping' described by Lazarus and Folkman (1984) can be adapted through the inclusion within the *Appraisal Process* of the concepts of *family resources* and *family situational appraisal* (including *family schema*, *family coherence* and

family paradigms) from McCubbin & McCubbin's (1996) family systems approach, in order to provide a unifying framework for *adjustment* as understood by health social workers.

Mutual Exclusivity

A common theme raised in relation to *Adjustment to Hospitalisation* was that this concept includes a more 'practical' orientation to issues of *adjustment* in the health-care environment. The need to *understand* the hospital system/environment and to *negotiate* or *communicate* effectively with a range of health professionals were commonly identified as key components of *Adjustment to Hospitalisation*. There was no broad agreement between respondents however, in relation to the issue of mutual exclusivity. Approximately one third of respondents stated that they believed *Adjustment to Health Condition* and *Adjustment to Hospitalisation* to be conceptually separate whereas the other two thirds did not. *Adjustment to Hospitalisation* was more generally understood by respondents to be a subset of *Adjustment to Health Condition.* While the *emotion* related aspects of adjustment were more commonly associated with *Adjustment to Health Condition*, and the *practical* related issues were more commonly related to *Adjustment to Hospitalisation*, it was noted that *Adjustment to Hospitalisation* could also include a component of *emotion* management.

Focus Groups Findings

Findings from the focus groups were generally in accord, with most participants agreeing with the presented findings and no major new insights were identified. Some participants noted that a diagrammatic representation of the social work processes relating to *adjustment* might look something like the layers of an onion or planetary model of concentric, inter-related factors. One person even suggested that such a representation might need to be holographic in order to represent the complexity and subtlety of the constantly interacting variables (including both *foreground* and *background*). There was general agreement that to promote the role of social work within health-care, a descriptive model for *adjustment* related practice should be developed.

Discussion

The findings identified that *adjustment* was conceptualised as a complex, multi-dimensional process including the key inter-related themes of *coping*, *emotion*, *subjective meaning*, *integration*, *adaptation*, *support*, *family-focus,* and *process orientation*. A range of theories were identified as informing

professional practice in relation to *adjustment* issues but there was agreement that the development of an integrative model to describe this practice concept would be beneficial. The dissemination of these findings may assist health social workers in better understanding and articulating this fundamental aspect of their work. It is important that social workers are able to accurately assess the key issues impacting on their clients so that their interventions are optimally targeted.

The findings also suggest that the NAHCC IFI codes *Adjustment to Health Condition* and *Adjustment to Hospitalisation* may need to be collapsed into a single entity with *Adjustment to Hospitalisation* forming a sub-category of *Adjustment to Health Condition*.

The conceptualisation of *adjustment* as a multi-dimensional process poses enormous challenges for the development of outcome measures for this important aspect of professional practice in health care. For example, the inter-relatedness of the sub-components within the *adjustment* process suggests that a range of outcomes may need to be measured. Reductionist approaches to measurement may run the risk of compromised validity if they attempt to separate these sub-components without recognising their inherent inter-relationships. The inter-relationships between sub-components are also likely to confound the development of causal explanations, and the ephemeral nature of many of these sub-components (eg. emotion) is likely to create problems in deciding upon dependant measures and in developing appropriate instrumentation.

The issue of selecting appropriate timing for outcome measurement is highlighted by the identification of *adjustment* as a process. A notable feature of social work practice in health care is its fluidity in responding to the often rapidly changing needs of clients. While measurement techniques such as goal attainment scaling have been successfully utilised in mental health settings where the focus may be limited to one particular issue, such methods are not adequate for measuring the multiple, rapidly changing goals encountered in acute health care.

Alongside the practical or pragmatic issues associated with researching and developing outcome measures for social work practice in relation to *adjustment*, consideration should be given to the ethics of attempting to measure such a sensitive area of practice. Researchers and evaluators will need to be

cognisant of the possibility that attempting to measure concepts such as 'emotional coping' may not only fundamentally alter the intervening processes (and therefore the outcomes) but may also be unnecessarily intrusive or even cause further trauma.

The present study is limited by having a relatively small number of respondents from only two metropolitan hospitals within a single Australian city. The study did not include social workers from rural health care settings or other specialist health care settings (eg. rehabilitation or sub-acute aged care centres). It is also possible that the findings may be influenced by idiosyncratic workplace culture factors within the two health care settings chosen. Despite these limitations, the study was able to provide an in-depth investigation of the research issues within the chosen research settings and the findings were found to have 'practice validity' within those contexts.

This study was also limited to the perspective of experienced professional social workers and did not attempt to ascertain the perceptions of other professional health care colleagues or the consumers of social work services within the health care settings. The findings therefore represent only one perspective on what *adjustment* means. Further research will need to be undertaken which includes other professional groups and also service users, in order to build a broader understanding of this important concept. Future research could also include diagnostic categories as dependant variables to further test for possible factors specific to medical diagnosis within health-related *adjustment*. It may be that specific forms of coping enhance *adjustment* relating to particular diagnoses.

Conclusion

The ability to accurately describe professional practice is fundamental to facilitating effective engagement with clients. This occurs through the provision of a common lexicon for 'problem' description which subsequently enables the development of mutually agreed upon goals for intervention. Social workers also need to be able to accurately assess *adjustment*-related issues in order to select appropriately targeted intervention strategies. The rationale for the present research study was to help inform and improve social work practice in health-care. It is hoped that the dissemination of the findings of this study will stimulate debate within the profession about the intended purposes of social work practice and the potential for outcomes measurement.

It is evident that the key concept of emotional adaptation to change events is likely to be relevant to many social service settings that also provide individual casework services. This would suggest that education in relation to working with *adjustment* should not be limited to health specific electives within tertiary educational courses, but rather be included as core material within generic social work training.

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