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FEELING THE STRAIN: JOB STRESS AND SATISFACTION OF DIRECT-CARE STAFF IN THE MENTAL HANDICAP SERVICE

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Introduction

Direct-care staff are arguably the most important employees in the Mental Handicap Service. Those who take care of the daily needs of people with a mental handicap are indispensabe and, therefore, it is vital that they are given adequate support in order to work effectively. To provide appropriate support one needs to look at the impact of work-related stress on individual staff members as well as those aspects of their job which give satisfaction.

Stress, Burnout and Depression

Menaghan and Merves (1984) looked at individual efforts to cope with problems in a variety of occupations defining stress as a discrepancy between environmental demands and individual capabilities. Direct-care staff may become stressed if either demands made on them are too great or they are inadequately equipped for the task. Work-related stress and satisfaction appear to be independent of each other and can co-exist (Bersani and Heifetz, 1985). Some staff will find a stressful task challenging and fulfilling, but many find continual excessive stress exhausting and "burnout" may result. This is a modern term used to describe the psychological strain which can result from constant interaction with people in need. Oswin (1978) studied nurses in long-stay mental handicap hospitals and described professional depression. This included feeling ineffectual, disappointed and angry about one's work, leading to becoming hardened to one's problems and giving up attempts to improve the situation. Firth *et al.* (1986) sent self-report questionnaires to hospital nurses working in general, psychiatric and mental handicap specialities to examine the relationship between burnout and depression. They concluded that Oswin's "professional depression" and the concept of burnout (particularly the emotional exhaustion aspect) have "much in common". Scores on the Beck Depression Inventory also showed

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correlation with feelings of being discouraged about work, but as the authors point out, it was beyond the scope of the study to clarify whether depressed workers reported more job dissatisfaction.

What does staff turnover show?

Using questionnaires, interviews and participant observation, job stress and satisfaction can be monitored directly. The Job Descriptive Index - a self-report questionnaire - has been frequently used to measure job satisfaction. Some studies looked at the health of staff as an indicator of stress using the Cornell Medical Index (Browner *et al.*, 1987). In Dublin an instrument has been developed to audit stress amongst staff in a large community-based mental handicap agency (McCormack and Halliday, 1988). Many studies use staff turnover as an objective measure of job stress or dissatisfaction but it is necessary to look at this carefully as increased stress does not *necessarily mean increased* turnover. Also one must establish whether an employee has left for reasons which are not stress related. Allen *et al.* (1990) found that factors which caused stress in staffed homes in Kent were also related to the propensity of staff to leave the service.

Organisational commitment was more important than job satisfaction in predicting which psychiatric technicians would leave a Californian institution, but the subject sample was rather small (Porter *et al.*, 1974). Another British study compared staff turnover of two houses serving eight residents and two units serving eighteen residents with similar handicaps (de Kock *et al.*, 1987). Turnover was higher in the smaller units, but many staff left for purely personal reasons and job dissatisfaction was not enlarged upon. Sample sizes were small and the data collected over a short period of time. Therefore, this study can only tentatively suggest that pressures may be greater in small units and one can only speculate as to what these pressures might be. The study of Allen *et al.* (1990) also found a slightly higher staff turnover in community homes when compared to hospital. However, the authors comment that community staff tended to be more mobile than hospital staff and therefore more likely to leave if stressed to the same degree. Therefore, one could not conclude that staff in the community might be under more stress than those in hospital. In fact Maher (1990) found no significant difference in turnover rates when hospital and community were compared.

So how do the staff perceive various aspects of their work?

(a) Working with residents

There are conflicting results from research into the impact on staff of residents' behaviour and progress. Sarata (1974) looked at a large number of employees of agencies providing mental handicap services in the North Eastern USA. Data showed lack of client progress was an important cause of staff dissatisfaction. Zaharia and Baumeister (1978) agreed that turnover was highest in the units for individuals with the most

severe handicaps. Conversely a comprehensive study using a large sample of staff in an American institution found lower turnover rates in areas which cared for individuals with more profound mental handicaps (Lakin *et al.*, 1982). Another small in-depth survey of American psychiatric technicians caring for individuals with profound mental handicaps showed that the residents provided the main source of job satisfaction (Browner *et al.*, 1987). In Britain, Allen *et al.* (1990) showed that hospital staff were stressed by reduced interaction with individual residents - a result of being responsible for large numbers of people. In both these latter studies violence and behaviour problems also caused concern.

Turning to community studies, a similar lack of agreement exists regarding the relationships between staff turnover and residents' characteristics. In Tennessee house-manager turnover was highest where residents' skills were lowest and behaviour problems most prominent, but the rather small sample of subjects may not have been in constant direct contact with the residents as they had management duties. (George and Baumeister, 1981). In contrast, direct-care workers in community residences in New York reported that residents provided the greatest source of both stress and satisfaction (Bersani and Heifetz, 1985). To quote the authors: "greater degrees of impairment in residents are not associated with either higher levels of stress or lower levels of satisfaction in staff". Again sample size was small but taken from a reasonable number of residences (each accommodating between three and thirteen people with a mental handicap). A weakness of this study is that a standardised instrument was not used (apart from a small 4-item adjunct). The self-administered questionnaires were devised by the research team. It is inevitable that the different studies will not give consistent results regarding the impact of residents' progress and behaviour on staff. The research methodology varied markedly with different populations, sample sizes and instruments used. The main point is that working with people who have a lot of problems can either be challenging and rewarding or exhausting - staff reaction will vary depending on the personality of the individual member of staff, the philosophy of the service or of the community. These studies were carried out across the USA and Britain and are bound to differ in results.

(b) Lack of control and role of staff

Staff commonly report that lack of control over their work causes stress, as was found in the study of institution staff by Browner *et al.* (1987). Direct care staff complained that plans were made for residents without consultation with them. Maher (1990) interviewed a small sample of nurses in depth following their transition from hospital to community work. They felt rewarded by the increased responsibility and control over their work. If greater control is given to direct care staff they must be supported and their role defined. Allen *et al.* (1990) found that being left to cope alone with a relatively ill-defined role contributed most to stress in community staffed

houses. In hospital, staff were stressed "when there was conflict between the way they wanted to carry out their role and the way in which they were able to do so."

(c) Isolation

Staff in community homes often report feeling isolated and this can be eased by good communication between direct-care staff and managers and between homes. A cause of stress for American psychiatric technicians in the study by Browner *et al.*, (1987) was poor communication with hospital administrators. Raynes *et al.*, (1990) studied communication in British staffed houses ranging in size from 3 to 31 beds. Staff in the smaller facilities were more satisfied with opportunities for discussion with peers than in large residences. The study also highlighted a problem of communication with line managers. Unfortunately, the results are very difficult to interpret as the self-report questionnaire used was not tested for validity or reliability. We are told only that over 1000 were returned and no information about the residents or staff complements of any of the facilities is given. Nurses interviewed by Maher (1990) in Bristol reported feeling lonely after moving from hospital to community work. They missed the camaraderie amongst hospital staff and also disliked the inability to get away from a client presenting a problem.

(d) Poor organisation and lack of reward

A significant cause of stress is concern over excess paperwork and shift schedules (Browner *et al.*, 1987). George and Baumeister (1981) found community staff complained of low pay and lack of opportunities for promotion, although Allen *et al.*, (1990) reported that staff in the community were more satisfied with these aspects than hospital staff.

(e) Personal issues

In the study by Allen *et al.*, (1990) staff were questioned about how their job fitted in with their requirements. Community staff were less satisfied with their hours of work than hospital staff. In this study questions were also asked about the status of the work (i.e. judgements made about it) and community staff were more satisfied than hospital staff over this issue.

Power and Sharp (1988) compared job stress and satisfaction of British mental handicap nurses with hospice nurses. Mental handicap nurses reported far lower job satisfaction in all areas except promotion. Stress was due to conflict with other nurses and the nursing environment. The authors commented that it may be difficult for nurses to aim for a goal of improving patient health in the impoverished nursing environment of institutions. This is an interesting study but mental handicap nurses were over-represented in numbers which cast a doubt on the validity of the result.

Are there any solutions in the literature?

(a) Individual efforts to cope with stress

Coping with stress at work has been extensively studied in many types

of occupation. For instance a study of 1000 employees of various occupations in Chicago (Menaghan and Merves, 1984) concluded that individual efforts to cope with stress are important, but relatively ineffectual in altering occupational conditions. A study of coping behaviour of engineers (Newton and Keenan, 1985) questioned whether 'universal coping techniques' can be applied regardless of the individual or the environment.

Coping techniques in the caring professions have also been studied. In her classic report Isobel Menzies studied the nursing service in a general teaching hospital in London (Menzies, 1967). Using psychodynamic theories she proposed various defence mechanisms which she felt nurses were using to avoid being overwhelmed by the distress of their patients. This included categorisation of patients (by bed numbers) and denial of feelings. Her findings can be extended to other areas of nursing, including mental handicap. Shinn and colleagues of New York University (Shinn *et al.*, 1984) sent questionnaires to various "human service workers", (social workers, psychiatrists, psychologists, nurses etc.) and concluded that individual coping responses tended to be based on practical goals (eg. relaxing when away from work) but ineffectual.

(b) Is support needed?

Allen and colleagues (1990) proposed three types of support which could be made available to staff:

- supply of resources including professional advice and training
- representation (managerial, political)
- socio-emotional (befriending, stress reduction)

Lack of training and support was cited as a major problem in community homes in Tennessee (George and Baumeister, 1981). Firth and Myers (1985) have highlighted the need for organisational and personal supports to maintain morale in community-based services in Britain. In their summary they suggested that support should include good communication, adequate staff numbers, involvement in decisions about clients, feedback and respect. Maher (1990) found that community staff felt more able to cope if their managers visited the homes regularly.

(c) Social support

Several studies looked at the use of social support. La Roccò *et al.*, (1980) studied men from a variety of occupations and concluded that "social support ameliorates the impact of occupational stress on job related strain and health". Another study used the Cornell Medical Index to measure the health of psychiatric technicians in American institutions and asked about social supports in and outside work (Browner *et al.*, 1987). Fewer health problems were found in the unit where teamwork was effective and where technicians also socialised outside work. However, the authors themselves pointed out that instruments for measuring both health and support need to be more sensitive to explore the correlations between these two variables.

On the Isle of Wight a pyramid support network was set up for staff working in hostels and small group

homes in the community (Crawford, 1990). An initial set of role analysis and developmental workshops for trained staff produced a list of needs for training which was subsequently carried out. Staff support groups then met several times a year outside the work environment for about four years. The staff reported benefit from the groups, but no detail of their comments is given and objective measures were not used. This study can only give a subjective opinion as to the usefulness of support groups in easing job stress.

Conclusion

There appears to be a significant problem of turnover amongst staff working with people with a mental handicap. Lakin (Lakin *et al.*, 1982) makes the comment "Personnel problems need to be improved before the normalisation of residents can ever be realised . . . it is not normal for dependent people to have a steady turnover of carers." George and Baumeister (1981) concluded that the community residential facilities in their study were not functioning well, as they were not providing a stable environment for residents and promoting contact with society outside the homes.

Staff turnover is related to job stress and satisfaction as this review shows. Management can improve working conditions of staff if the perceived causes of stress are addressed. At the recruitment stage, one is more likely to select a suitable employee if the particular stresses of the area of work in question are known. This sort of information will also be of help to a candidate for a post who needs to select work suited to his or her skills and personality. Morale will be improved by general aspects of a job such as a good standard of pay and promotion, adequate staffing ratios and a pleasant working environment. Good management of a unit will include efficient organisation of nursing shifts, effective communication at all levels and involvement of direct-care staff in important discussions. Personal advice from a manager should be available if staff are unsure of their role or conflicts between them arise. It is important that managers of community homes achieve a balance between promoting autonomy and supporting staff to prevent feelings of isolation (Maher, 1990).

There are relatively few published studies of stress experienced by staff in British community homes. More research is needed in this area, in particular, more detailed description of work-related stress and satisfaction. This review highlights the need for supportive schemes including in-service training and social support such as discussion groups. Ideally, objective evaluation of such schemes should be carried out. It is likely that staff will suffer less anxiety about residents' behaviour or lack of progress if they are given adequate information, or a chance to express their concern without the fear that they will be seen to have failed. Services for people with a mental handicap will only run well if the direct-care staff are given adequate encouragement and support.

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