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**STRESS AND COPING
AMONG DIRECT CARE STAFF
IN A LEARNING DISABILITY SERVICE**

ELIZABETH WHITEHEAD

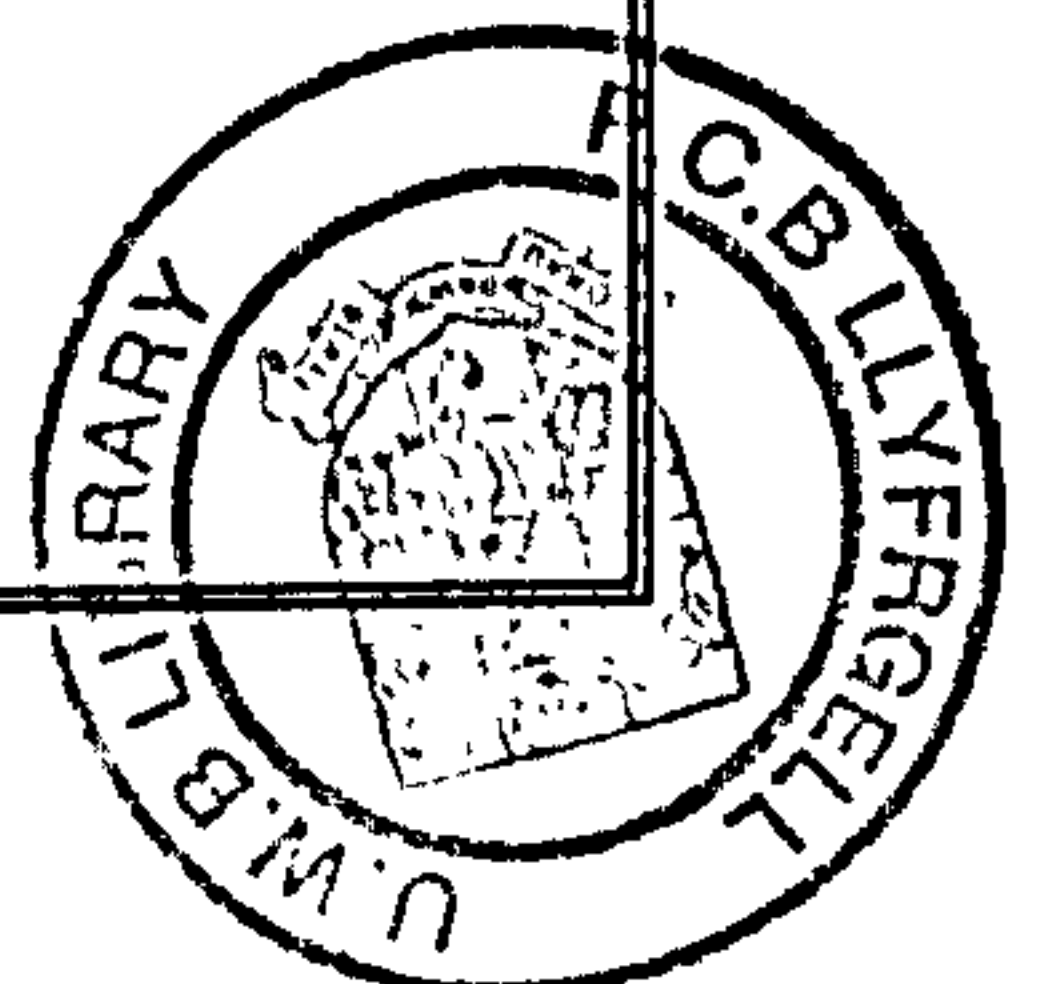
**THESIS SUBMITTED FOR THE DEGREE
OF DOCTORATE IN CLINICAL PSYCHOLOGY**

**UNIVERSITY OF WALES
BANGOR**

JULY 1999

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ABSTRACT

A survey of direct care staff from four different teams with a learning disability service examined stress and coping. The four teams included two specialist support teams, one hospital team and one community based support team. Teams were matched on the client group they worked with; people with a learning disability and challenging behaviour. Thirty-two respondents (21 women and 11 men) provided data relating to perceived occupational stress, coping styles, levels of support and burnout. In response to research evidence of a relationship between levels of stress and occupational factors, it was hypothesised that staff in such services would have high levels of stress and would experience burnout. It was also hypothesised that individual coping style and perceived level of support would be associated with stress levels, and that there would be significant differences between the teams on these variables. The survey measures were the General Health Questionnaire (Goldberg & Williams, 1988), the Occupational Stress Inventory (Osipow & Spokane, 1987), the Maslach Burnout Inventory (Maslach & Jackson, 1981), the Shortened Ways of Coping Questionnaire (Harris & Thompson, 1993). Correlational analysis indicated that (a) the staff under study reported significantly higher stress levels than comparison groups and that (b) emotion focused coping style and staff support were significantly correlated to stress and burnout levels. The study also found significant differences between the four teams on some aspects of occupation role and burnout measures. The findings confirm and extend previous research, and provide new information on staff stress in different models of service delivery. Implications for intervention and future research are discussed.

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DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

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OVERVIEW

In recent years there have been many changes in the provision of services to people who have a learning disability. The Government White paper “Better Services for the Mentally Handicapped” (DHSS, 1971) signalled the move away from institutional care and the beginning of community care policies. Between 1980 and 1993, over 26,000 people with a learning disability had been resettled from the old style mental handicap hospitals into the community (Emerson and Hatton, 1994). The pace at which hospital-based provision was reduced varied significantly at the regional level, as did interpretations of government policy. In Wales, the production of the “All Wales Strategy” (AWS) (Welsh Office, 1983) provided a 10 year plan for achieving community living for people with a learning disability. The AWS document provided both a clear philosophy and fundamental objectives for achieving the aims of government policy on community care. Principles included in the AWS state that all people, irrespective of the degree of learning disability have a right to:

- a) normal patterns of life within the community
- b) be treated as individuals
- c) receive support from the communities in which they live and from professional services.

Very generally, the first wave of de-institutionalisation in the UK involved people with the least severe disabilities, often to pre-existing services such as hostels and family placement schemes (Korman and Glennerster, 1990). During the 1980’s attention focused on the development of community-based provision for people with more severe disabilities, including those with additional needs such as multiple disabilities and ‘challenging’ behaviour (DoH, 1993).

Emerson (1990) defined challenging behaviour as:

“behaviour of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy or behaviour which is likely to seriously limit or deny access to the use of community facilities. Ordinarily, it would be expected that the person would have shown the pattern of behaviour that presents such a challenge to services for a considerable period of time. Severe challenging behaviour is not a transient phenomenon.”

Examples of challenging behaviour include aggression to others (eg, hitting, kicking), self-injury (eg, head-banging, eye-poking), self-stimulatory (eg, body-rocking, pacing), destruction to property and anti-social behaviours (eg, screaming, stripping).

The needs of this client group are often so complex that they, and their carers, require very high levels of support in order to achieve the aims of community living.

In order to meet those needs and in line with the principles of the AWS, new models of service provision have been developed, including peripatetic and specialist support teams.

There has been a considerable body of research assessing the effects of transition to the community on the lives of people with a learning disability. There is also growing research on the staff who work with this client group, in both hospital and community settings. There is, however, no research specifically investigating staff issues in peripatetic models of service delivery. The present study attempts to redress the balance, by looking at staff stress in four models of service delivery – one ‘traditional’ hospital model and three different community-based models, all supporting clients with challenging behaviour.

The author's interest in the topic of staff stress originated while employed in a learning disability service. An opportunity arose to conduct a small-scale qualitative research project, with a senior colleague. The project centred around the satisfactions and frustrations of staff working in a learning disability hospital. Consistent themes were identified and explored in more depth. The results of the project were presented in a document to the hospital's senior management team. Recommendations made in the document were taken up by the management team and resulted in the setting up of a free, independent counselling service being made available to all the hospital staff. Later, this service was extended to include all employees in the learning disability service and indications are that the counselling service has been well utilised by staff. Both the original project and the subsequent counselling service generated much interest in the topic of staff stress, at all levels. Issues relating to staff stress have remained a high priority in the learning disability service and the present study represents an extension and further exploration of the original project.

INTRODUCTION

This study examines stress and coping in direct care staff working in a learning disability service. The introduction section of the study begins with a brief explanation of the concept and definition of stress. It then examines some general models of stress and more specific models of occupational stress. The related concepts of burnout, coping and the role of support are examined.

Research on these concepts in the context of health professions is discussed. Finally, the above issues are examined specifically in relation to staff working in learning disability services.

THE CONCEPT OF STRESS

The Oxford English Dictionary (1995) describes stress as the “effort and demand upon the physical and mental energy of the human body”. The word stress probably originated in an engineering context, and while most people have a conceptualisation of what stress is, the use of the word stress can cause confusion. There is some agreement, however, on a basic overview for academic study. There are a number of “stressors” or causes of dysfunction, strain or ill health. This dysfunction is reflected in dependant variables related to the state of being stressed as evidenced by physiological, psychological or behavioural indices (e.g. Fletcher, 1988).

Within this framework, a wide range of different stressors have been identified, which, if not adequately responded to, can have deleterious effects on both the individual and the organisation they work in. For the individual, the effects of stress can result in increased medical risk such as coronary disease, ulcers, high blood pressure, anxiety, depression, alcohol abuse and smoking. For organisations, the dysfunctions can include increased absenteeism, poor productivity, high staff turnover and poor labour relations (Arnold, Robertson & Cooper, 1991).

A number of factors can act to moderate these stressors including domestic and social factors, personality and motivation. Attempting to combine the relationships between stressors, strains and the influence of moderating factors into an adequate model of stress has been a daunting task for researchers and has produced many alternatives. It is beyond the scope of this study to examine all the models, and the models chosen here serve to illustrate some important developments in the conceptualisation of stress research.

MODELS OF STRESS

Early models of stress were general in nature, and have been useful in providing a basic framework for the understanding of the general concept of stress. For example, the General Adaptation Syndrome (GAS) (Selye, 1983) proposes that if an individual is exposed to a physical or psychological stressor, they may respond in three stages, depending on the intensity or chronicity of the stimulus and the coping mechanisms utilised by the individual. In the first stage, the alarm reaction, the body shows diminished resistance to the stressor. In the second stage, resistance rises above normal or adapts to the stressor. In the third stage, exhaustion will result if exposure to the stressor persists or is not adequately responded to in the adaptation stage. Selye proposed four classifications of stressor, eustress (good stressors), distress (distress, bad stressors), hyperstress (too much stress) and hypostress (too little stress) which are based on two axes of degree and type of stress. Eustress is a state that occurs when stimulation is optimal and functioning is normal; distress occurs when stimulation is too high or too low and results in the GAS being activated.

Selye's model has been criticised as being too simplistic (Mason, 1975) on the grounds that the concept of stress being a non-specific physiological response is inadequate. In Selye's model, the basic assumption is that all stressors originate from the proximal environment, thus leaving no room for the role of cognition. It does not

explicitly acknowledge the possibility that more distal environmental events could shape an individual's response to a stressor. It is likely that stressors could emanate from within (psychoanalytic theory) or that previous experiences shape the individuals appraisal of the event as too stressful or not (learning theory).

MODELS OF OCCUPATIONAL STRESS

Many models that relate specifically to occupational stress have been developed. Early, influential models such as that of Kahn, Rolfe, Snoek and Rosenthal (1964) tended to focus on specific job factors which were perceived as threatening to individuals. In these models, stress was considered to be the result of mismatch between an individual's abilities and the requirements of their work. Stress would occur either if excessive demands are made of employees or if employees were not adequately equipped to cope with stressful situations. The Person-Environment Fit Model (French, Caplan and Van Harrison, 1982) makes an important distinction between objective and subjective environments. The objective elements of the model refer to the outside world, independent of the individual's perception of it. The subjective elements refer to the individual's perception of how the world affects them. In this model, there exists a propensity for strain if the objective environment and the objective person "do not fit". In this model, degree of misfit between the individual's perception of themselves and their perception of the environment is the main predictor of strain. However, an individual may have developed strategies to cope adequately with any misfit between objective elements, and thus modify the resulting strain.

In Karasek's Model (1979) strain is considered not only as a function of job demand but also of discretion (similarly described as job decision latitude or autonomy). Karasek's model has the advantage of being relatively easy to test, and the consistent finding has been that a combination of low decision latitude and high job demands are associated with mental strain, coronary heart disease and job dissatisfaction. In a

recent study, Karasek (1990) examined the relationship between health status and control in white-collar workers. The effects of control or autonomy were assessed by job changes and reorganisation where employees increased or decreased decision latitude, compared to a control group which had no change in decision latitude. The results showed predicted effects on health status with a variety of health outcomes. These findings have important implications for redesigning work as they imply that greater job discretion could have significant benefits for employees even if job demands remain high. More recent studies (ie, Warr, 1991, Fletcher and Jones, 1993) have found that even though discretion and demand generally predicted strain, the relationship between the two was not significant.

A related and extended model of stress was proposed by Payne (1979; 1980) in his Demands, Supports, Constraints Model. In this model it is suggested that a wide range of variables be encompassed within a framework which involves a balance between these variables. Demand is defined as “the degree to which the environment contains stimuli which pre-emptorily command the person’s attention and response”. Demands are modified by support – “the degree to which the environment makes available resources relevant to demands placed upon the system”. Both demands and supports are in turn modified by constraints, defined as “the degree to which the environment constricts, confines or prevents the system from surviving the demands placed upon it”. Supports are positive factors, while constraints are negative factors, both of which influence coping with the demands. Thus in Payne’s model strain results from a lack of balance between the three component variables. In real terms the model implies that high demands will not inevitably lead to high levels of strain, if there are low levels of constraint and high levels of support. This has important practical implications; it is not always possible to reduce the levels of job demands and this model suggests that it may not be necessary. Increasing support and / or reducing constraints can act to lower the levels of strain. Payne’s model has been

used to describe a general framework for stress in health professionals (Payne and Frith – Cozens, 1987) and has been used to predict strain in various occupational groups including taxi drivers (Fletcher and Morris, 1989), health visitors (Fletcher, Jones and McGregor – Cheers, 1991) and psychiatric nurses (Janman, Jones, Payne and Rick, 1988).

The demands, supports, constraints model has some limitations. For example, it does not take into account individual differences and some recent literature suggests that particular psychological types may be over-represented in the human services professions (Garden, 1989). Despite this, the model does encompass a number of elements found in a variety of models and has proven utility. For these reasons, it was chosen as the underlying theoretical framework for the current study and influenced the selection of questionnaire to be employed.

STRESS AND BURNOUT

One of the effects of prolonged occupational stress that has received much attention in recent years, is that of 'burnout' (Freudenberger, 1974). Burnout is a concept that has been associated with psychological distress in the caring professions. Maslach and Jackson (1981) describe burnout as a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment.

Emotional exhaustion is characterised by a lack of energy (physical and mental) and a feeling that one's emotional resources are 'used up'. Sometimes referred to as 'compassion fatigue' it may co-exist with feelings of frustration and tension as workers realise they are no longer able to give of themselves as they once could. A common symptom is dread at the prospect of going to work each day (Cordes & Dougherty, 1993).

Depersonalisation is marked by the treatment of clients as objects rather than people. Workers may display a detached and callous attitude to those in their care. Visible symptoms may include the use of derogatory labels (eg, the “schizophrenic” on ward 3), physical withdrawal through extended breaks, conversations with co-workers and extensive use of jargon.

The final component, diminished personal accomplishment, is characterised by a tendency to evaluate oneself negatively. Individuals may experience a decline of feelings of job competence and performance, and may report feeling unappreciated.

Maslach and Jackson (1981) felt that individuals involved in prolonged intensive interactions with people in an emotionally charged atmosphere are susceptible to the syndrome, which is a continuous rather than a dichotomous variable. Maslach and Jackson defined burnout as “the loss of concern for people for whom one is working, including physical exhaustion and characterised by emotional exhaustion in which the professional no longer has any positive feeling, sympathy or respect for clients or patients” (pg 52). It has also been described as a maladaptive psycho-physiological and behavioural response to the effects of occupational stressors (Cronin-Stubbs and Rooks, 1985).

Cherniss (1980) described a three stage model of burnout where a perceived imbalance between demand and resources lead to the short term effects of anxiety, tension and fatigue and also the longer term effects of changes in attitude and behaviour, manifested as an increased degree of cynicism and detachment. Davidson and Jackson (1985) describe other symptoms in the cluster surrounding the syndrome to include fatalism, callousness, patient victimisation, verbal aggression, dehumanisation and emotionally impoverished relationships.

Bailey (1988) encapsulates the relationship between stress and burnout as “stress as the snapshot, burnout as the movie”, with stress being the product at any one moment while burnout refers to the process that appears to be generally taking place in chronically stressed individuals with the passage of time. In terms of a model of stress, burnout can be viewed as a manifestation of strain. Burnout is considered to have close links with the quality of the organisational environment (Leiter, 1991). Exposure to stressors appears to be a necessary condition for burnout to occur and correlations have been found between some aspects of stress and burnout (eg, Sonnetag, Brodbeck, Heinbokel and Stolte, 1994), but burnout does not seem to be inevitable. Many people experience stressors and do not burnout (Mulday, 1983). This suggests that the experience of burnout may be moderated by intervening variables. These variables may be broadly classified into three categories - situational, intrapersonal and interpersonal. Situational variables include demographic characteristics such as age, education, occupational role and work setting. Intrapersonal variables include personal coping strategies and finally interpersonal variables, which include the influence of peer and social support.

COPING

Much of the coping research and literature derives from the stress and coping theory of Lazarus and Folkman (1984). They posited that an event becomes stressful if it is appraised by an individual as a threat to their level of well-being. Once the event has been appraised as stressful, the individual can attempt to deal with this threat through a variety of coping strategies. Coping can be defined as any response to external life stressors that serves to prevent, avoid or control emotional distress (Aldwin and Revenson, 1987). Coping involves actions, both overt and covert that may reduce or eliminate psychological distress (Fleishman, 1984).

Given the array of potential stressors and the variety of individual responses available to deal with them, it is not surprising that different explanations of the coping process have been formulated. Early approaches favoured ego-defensive mechanisms (ie, Haan, 1977) and trait explanations (ie, Moos, 1974). More recently, cognitive models of coping suggest that coping strategies utilised by an individual are influenced, not only by the actual appraisal of an event, but also by the individual's coping resources, which can be both internal and external.

Billings and Moos (1981) describe three types of coping strategies; active-cognitive strategies (managing the appraisal of an event) active-behavioural strategies (dealing directly with the event) and avoidance strategies. Lazarus and Folkman's (1984) theoretical framework originally distinguished between two major types of foci of coping: emotion-focused coping and problem-focused coping. In their formulation, coping is situation-specific; that is, it comes into play in specific situations, such as being confronted with an unreasonable deadline or a difficult manager. Problem-focused coping is defined as an attempt to alter or manage the situation (eg, "made a plan of action and followed it") by dealing directly with the event that is provoking distress. Emotion-focused coping is defined as an attempt to reduce or manage emotional distress (eg, "tried to look on the bright side", "pretend it wasn't happening") and may include avoidance, self-blame and wishful thinking.

The links between the use of specific coping efforts and levels of psychological functioning are well established. Active problem-solving appears to have a positive effect on personal well-being (Folkman et al, 1986) while the use of emotional-focused coping is likely to be linked to poorer levels of psychological adjustment in the longer term (Terry, 1991).

BURNOUT AND COPING IN HEALTH PROFESSIONS

Research findings relating to burnout and coping in health professions have been somewhat mixed. Kinmel (1981) in his study of 135 health care workers, found self-blame coping was positively related to burnout, whereas Keller (1982) found no association. Maslach and Jackson (1982) found higher levels of burnout amongst workers employing withdrawal strategies. Pratt and Andrews (1988) studied 312 nurses and found that of all the factors examined, emotion-focused and problem-focused coping were, respectively, among the most powerful positive and negative predictors of burnout.

These findings are supported by Ceslowitz (1989) who found nurses who used escape or avoidance strategies experienced increased levels of burnout, and Boyle, Grap, Younger and Thornby (1991) found a similar correlation.

Very few studies have examined the coping strategies used by direct care staff in learning disability services, and those that do exist tend to look at staff in either hospital or residential community settings (ie, Thomson, 1987; Hatton and Emerson, 1995).

One of the aims of the present study was to assess the coping strategies of direct care staff in specialist teams working with learning disability clients who had challenging behaviour and examine the relationship of such strategies to stress in general and burnout in particular.

THE ROLE OF SUPPORT

The importance of providing social support to moderate the harmful effects of stress has been well documented in the occupational stress literature (Payne, 1980). Pines (1983) lists six basic functions of a social support system: emotional challenge,

emotional support, technical challenge and the sharing and testing of social reality. He also provides evidence that listening and emotional support are amongst the most important and that a lack of these two can correlate significantly with negative outcomes. Similarly, Crawford (1990) has shown that supportive relationships between colleagues are important in maintaining staff morale and appear to moderate the effects of stress. Browner et al (1987) found that a lack of organisational support factors such as consultation, decision latitude and feedback on performance can lead to potentially stressful outcomes. Harris and Thompson (1993) suggest that a good support system will be one that effectively synthesises organisational and personal support, and have developed a questionnaire to evaluate staff support in learning disability services.

STAFF STRESS IN LEARNING DISABILITY SERVICES

Until quite recently, staff issues in learning disability services have received little attention in the literature. From studies that are available, the evidence strongly suggests that workplace stress is a major problem for staff, organisations, and in turn, recipients of services. Hatton and Emerson (1993a) found that approximately 30% of staff in learning disability services report high levels of stress, although there is wide variation between different services. Levels of staff turnover also vary widely between services, with some services reporting an annual turnover rate as high as 50% (Hatton et al, 1995). If accurate, this may represent both a serious lack of continuity of care provided to service users and high costs to service providers, in terms of recruitment and training.

There is also increasing evidence that some forms of staff activity, such as direct assistance, are very closely related to the quality of life of service users (Felce, 1996) and that some community-based residents receive very low levels of staff support (Emerson & Hatton, 1994). These findings suggest that changes in service models in

themselves are not inevitably promoting good staff performance or better lifestyles for residents. That variation between services exists also suggests that working with learning disability clients does not inevitably lead to high staff stress, and that a number of mediating factors may be involved.

Most of the available research utilises correlational methods in an attempt to determine which factors are associated with staff stress and performance, which may impact on the lives of the service users. These factors can be broadly grouped into a number of domains:

Within-staff factors – included here are anxiety (Browner et al, 1987) and personal health (Power & Sharp, 1988), staff beliefs and emotional reactions to service users (Bromley & Emerson, 1995) and coping strategies of staff (Hatton & Emerson).

Characteristics of service users – such studies tend to focus on the challenging behaviour of service users (Bersani and Heifetz, 1985; Rose, 1993; Bromley and Emerson, 1995).

Job factors – including work overload (Razza, 1993; Rose, 1993), lack of job variety (Allen, Pahl and Quine, 1990) and low income (Bersani et al, 1985).

Role in the organisation – role ambiguity and role conflict have been strongly implicated with levels of staff stress (Razza, 1993; Allen et al, 1990)

Career prospects – factors such as job security (Rose, 1995), lack of promotion and lack or limited training opportunities (Hatton & Emerson, 1993b; Rose, 1995) have been identified as important factors.

Social support – practical and emotional support from supervisors, managers and colleagues (Browner et al, 1987; Razza, 1993 and Rose, 1995) and job performance feedback (Hatton & Emerson, 1993b) have been included in this domain.

In addition to providing a list of factors linked to staff stress, research has begun to examine which factors have the most impact on staff stress. Some studies have shown that in services where staff support is low, user challenging behaviour is rated more stressful than organisational factors (eg, Hatton et al, 1995) although other studies have found that staff rate role in the organisation as most stressful (eg, Bersani and Heifeltz, 1995).

There have been some attempts to separate general and workplace stress. Early findings suggest that the work-home interface and coping strategies have the biggest impact on general stress, whereas occupational factors are more influential on work stress (eg, Hatton et al, 1995).

The research in this area has tended to be small scale, making findings somewhat tentative. Attempts to increase sample size have meant that there is a tendency to be over-inclusive, with all staff from managers to auxiliaries participating. Clearly, this practise does not address a most central issue; that different occupations will, by definition, face different stressors, even within the same service. Previous studies have also included a wide array of factors, producing seemingly limitless associations. While interesting, these associations do not usefully inform practitioners as to which factors are pertinent to specific staff groups and thereby reduce the possibility of effective intervention. The present study aimed to reduce the number of possible variables associated with staff stress in order to identify which factors have the most impact for specific staff groups, employed in current models of service delivery for people with a learning disability.

AIMS OF THE CURRENT STUDY

The current study aimed to conduct a survey of direct care staff in services for people with learning disabilities, specifically staff in specialist teams working with people whose behaviour challenges services. The aims of the study were as follows:

1. To examine levels of staff stress in a learning disability service and compare them with other populations where possible.
2. To describe the basic characteristics of staff and their working conditions.
3. To investigate potential influences on staff outcomes (namely stress and burnout) including organisational factors and coping strategies.
4. To examine differences in staff outcomes, organisational factors and coping strategies between the different staff groups.

HYPOTHESES

1. That the stress levels of direct care staff will be statistically significantly higher than the stress levels of a comparison group, as measured on the GHQ. The comparison group will be all adults administered the GHQ in the Health Survey for England (Bennett, Dodd, Flatley, Freeth and Bolling, 1995). In this survey, 16% scored on or above the cut off level.
2. **Coping**
That there will be (a) statistically significant positive correlations between measures of occupational stress as measured on the OSI, general stress as measured on the GHQ and emotion-based coping style, as measured on the SWC-R, and also (b) on the longer term effects of stress as measured by MBI.

3. Occupational Roles

That there will be a statistically significant positive correlation between (a) aspects of occupational roles measured on the OSI and stress, measures on the vocational strain (VS) subscale and the GHQ. Also (b) occupational roles and burnout, as measured on the OSI and MBI.

4. Staff Support

That there will be (a) statistically significant negative correlation between staff support, measured on the SSQ and stress levels, as measured on both the GHQ and OSI. Also (b) that a similar correlation will be found on the measures of staff support (SSQ) and burnout (MBI).

5. That there will be statistically significant differences between mean stress levels measured on the GHQ, the VS and the MBI, between the four teams. There would also be significant differences on coping, support and aspects of occupational roles between the teams. Specifically, it was hypothesised that the two specialist teams (AST and EIS) would report higher levels of stress than either the hospital or community teams.

Design – for hypothesis 1, a between-groups independence of classification design was employed. Hypotheses 2, 3 and 4 employed a within-group correlational design. Hypothesis 5 employed a one-way analysis of variance design.

METHOD

PARTICIPANTS

Four staff teams working directly with people who have a learning disability and challenging behaviour were selected for this study.

Team 1

A hospital-based team working with clients with high rates of challenging behaviour. The hospital had approximately 120 long-stay adult residents with a range of learning disabilities from mild to severe, profound and multiple disabilities. The residents were housed in villa type accommodation with all services on site. These services included recreational activities, education and medical services, including psychiatry, psychology, physiotherapy and occupational therapy. The staff under study worked in a villa which housed 10 male residents, many of whom exhibited high rates of challenging behaviour and who had a range of disabilities including autism, dual-diagnosis, epilepsy and severe stereotypy (ie, head-banging and other forms of self-injury). Challenging behaviour rates in the hospital were recorded and collated monthly. These included incidents of aggression (to persons or property), seclusion (time-out in a designated room) and emergency medication. Based on these monthly figures, the team under study were working with the most challenging clients in the hospital. Many of these clients had limited access to day services because of their behaviour and some of them spent a high proportion of each day on their villa. At the time of study, the residents and staff were temporarily housed in another, smaller villa while refurbishment work was being carried out in their usual villa. Staff in this team worked a normal 8 hour shift pattern, with paid overtime available. At the time of study, the hospital had been operational for approximately 26 years.

Team 2

An additional support team (AST), a specialist peripatetic service which provided additional support to clients with challenging behaviours and their carers. The AST worked alongside, not instead of, other community support services as part of a multi-disciplinary team. The AST aims include a reduction in the levels of challenging behaviour for each client referred to the service by providing assessment and intervention. It operated a written contract system which detailed the agreed support and length of input. Among its aims were to teach functionally equivalent skills to referred clients and provide training to improve and expand competencies to a range of carers from different agencies. The AST work in a variety of settings including home and residential, school and day centres. Team members undergo training in observational skills and care and responsibility (C&R) procedures. Such procedures are individually designed physical intervention skills to be used in times of crises (eg, when physical restraint is required). Although most of the work was undertaken during normal working hours, there were times when staff were required to work longer, unsocial hours, often at short notice, which was managed on a rota basis. At the time of study, the additional support service had been operational for approximately 10 years.

Team 3

An emergency intervention team (EIS). A community-based team who worked with existing learning disability, generic health and social services in order to identify, prevent and manage crisis situations for people with a learning disability. It provided outreach peripatetic support to clients and carers during periods of crisis (ie, the breakdown of residential placement) in order that such clients are supported in their usual place of residence. It also provided safe residential care in a purpose-built community house, if it became necessary to temporarily remove clients from their local community. The maximum length of stay in the house was 13 weeks, with some

clients staying a few days and others the maximum time allowed. The mission statement of the EIS describes itself as a 'last resort service' to be used when all other potential options have been exhausted. Like the AST, the EIS staff worked in a variety of settings within the community and were trained in similar skills. The working hours of this team were similar to that of the AST, including 'on-call' duties. Additionally, when the community house had clients staying, staff were required to perform sleeping-in duties. At the time of study, the emergency intervention service had been operational for approximately 10 months.

Team 4

A community-based team who work with a range of clients who have a learning disability. The community learning disability team is made up of personnel from both health and social services. The team provided a range of services for all people on the learning disability register in a designated geographical area. The team include social workers, nurses, support workers, occupational and physiotherapists, psychiatrists and psychologists. The team operated a case management system, whereby a named professional acts as a manager to each individual client and is responsible for co-ordinating all services for that client. Each case manager carries a varied caseload; some clients required very little input from services, while the needs of other clients were multiple and complex. Traditionally, health service personnel (ie, nurses trained in work with learning disability clients) managed the bulk of clients whose behaviour challenged services. At the time of study the community team had been operational for approximately 19 years. Throughout the duration of the study the community team were in the process of relocation to a new base in a nearby town.

All participants were employed in the NHS and were matched on the type of client group they worked with. Only staff who worked directly with clients with a learning disability and challenging behaviour were invited to participate, as administrative and

domestic staff although part of the services, were considered to have different types of stress to direct care workers, which may have affected the results.

Teams 2, 3 and 4 had a total of 8 members each; team 1 had 16 members but only 8 were asked to respond in order to match the numbers in the other teams.

A total of 32 questionnaires were distributed, eight to each team, the response rate across the four teams was 100%.

The characteristics of the teams can be seen in Table 1, overleaf.

TABLE 1 - CHARACTERISTICS OF TEAMS – MEANS AND RANGE

Team	No of Participants	Age	Length of Time in Present Job	Length of Time in Learning Disability Services	Gender	Marital Status Partner / Single	Dependants Yes / No	Qualified / Unqualified
1. Hospital (residential)	8	34.8yrs (29 – 42)	8.3yrs (1 – 19)	14.1yrs (8 – 19)	4m : 4f	7:1	6:2	4:4
2. Additional Support (community)	8	35yrs (26 – 44)	3.5yrs (1 – 9)	14.3yrs (1 – 22)	3m : 5f	6:2	7:1	5:3
3. Emergency Intervention Team (community / residential)	8	38.5yrs (31 – 48)	9.2mths* (2 – 12mths)	8.8yrs (4 – 14)	3m : 5f	7:1	5:3	1:7
4. Community	8	42.6yrs (32 – 54)	5.8yrs (.11 – 10)	12.8 (2 – 30)	1m : 7f	7:1	6:2	7:1
Total	32	37.7yrs (26 – 54)	4.3yrs (excluding team 3)	12.5yrs (1 – 30)	11m : 21f	27:5	24:8	15:17

* Footnote – Team 3 was a new service that had been operational for only one year at the time of study. As some staff had been in post for only 2 months when data were collected, the team has been excluded from the total means in order to give a more accurate reflection of the total length of time in present job for the whole sample.

MEASURES

General Health Questionnaire (12) (Goldberg & Williams, 1988).

The GHQ is a validated self-administered screening test which focuses on the psychological components of ill health. It has been widely used as an outcome measure in studies of occupational stress (ie, Borrill, Wall, West, Hardy, Shapiro, Carter, Golya and Haynes, 1996; Bennett, Dodd, Flatley, Freeth and Bolling, 1995). The present study employed the 12-item version of the test, for which split-half reliability was found to be 0.83; concurrent validity with the Clinical Interview Schedule was found to be 0.81.

The four-point response scale on the GHQ (12) may be scored in two ways; either a Likert Scale or a bimodal response scale. The bimodal response method was selected for the present study as it is a very simple method of scoring, and it eliminates any errors due to 'end' or 'middle' users, since they will score the same irrespective of whether they tend to prefer columns 1 and 4, or columns 2 and 3 as only pathological deviations from normal signal possession of the item.

A score of four or more on the GHQ (12) is accepted as an indication that the respondent is likely to be experiencing high levels of distress and mental health problems. (See Appendix 1).

Maslach Burnout Inventory (Maslach and Jackson, 1981).

The MBI is a validated, 22-item self-administered screening test designed to assess the three aspects of the burnout syndrome: emotional exhaustion, depersonalisation and personal accomplishment. Each aspect is measured by a separate sub-scale, each sub-scale is assessed using a six-point, fully anchored response format. Test-retest reliability coefficients for the three sub-scales were found to be 0.82, 0.60 and 0.80 respectively. (See Appendix 2).

The Occupational Stress Inventory (Osipow and Spokane, 1987).

The OSI is a 140-item, self-administered measure of three domains of occupational adjustment. The inventory consists of three separate sections: the Personal Strain Questionnaire, the Occupational Roles Questionnaire and the Personal Resources Questionnaire. The manual states that while the average elevations for the three sets of scales provide an overview, the individual scales provide a detailed view of each of the domains and allow a more exact analysis of the operating stresses, strains and resources and thus can be measured separately. In the present study, only the first two sections were used, as questions relating to personal resources were available via the other questionnaires used in the study. The Personal Strain Questionnaire is a measure of the domain of psychological strain and is comprised of four scales. Vocational strain (VS) measures the extent to which the individual is experiencing problems in work quality or output. It also measures attitudes to work. Psychological Strain (PSY) measures the extent of psychological and / or emotional problems experienced by the individual. Interpersonal Strain (IS) measures the extent of disruption in interpersonal relationships. Physical strain (PHS) measures complaints about physical illness or poor self-care habits, as these measures are included in the GHQ-12 they were not included in the present study. The Occupational Roles Questionnaire is a set of six scales designed to measure occupational stress by examining specific attributes of the work environment. (1) Role Overload (RO), measures the extent to which job demands exceed personal and / or workplace resources and the extent to which an individual is able to accomplish expected workloads. (2) Role Insufficiency (RI) measures the extent to which an individual's training, education, skills and experience are appropriate to job requirements. (3) Role Ambiguity measures the extent to which the priorities, expectations and evaluation criteria are clear to the individual. (4) Role Boundary measures the extent to which an individual is experiencing conflicting role demands and loyalties in the work environment. (5) Responsibility (R) measures the extent to which an individual

has or feels responsibility for the performance and welfare of others (clients and colleagues) in a work setting. (6) Physical Environment (PE) this scale is concerned with extreme physical conditions or high levels of environmental toxins. Given the working conditions of the teams under study, it was not thought appropriate to include this scale in the present investigation. Test-retest reliability coefficients for each section were found to be 0.90, 0.94 and 0.88 respectively.

Responses are made using a 5-point scale, which assesses the frequency with which an item applies to the respondent. Raw scores are converted to T-scores, based on normative data and are provided separately for male and female respondents. (See Appendix 3).

The Shortened Ways of Coping (Revised) Questionnaire (Hatton & Emerson, 1994)

The SWC-R is a 14-item, self-administered measure of staff coping strategies. It has been validated on staff working in learning disability services and the two sub-scales, Practical Coping and Wishful Thinking have test-retest reliabilities of 0.88 and 0.81 respectively. Practical coping corresponds to problem-focused coping and wishful thinking corresponds to emotion-focused coping in Lazarus and Folkman's model described earlier. Responses are made using a 4-point scale which assess the frequency with which an item applies to the respondent. (See Appendix 4).

The Staff Support Questionnaire (Harris & Thompson, 1993)

The SSQ is a 20-item measure of staff support in learning disability settings. Test re-test reliability was found to be 0.89; concurrent validity with the GHQ was found to be 0.60. Although the latter figure was below the usual accepted level, the rationale for including the SSQ in the present study was that it has been designed specifically as a means of measuring support among staff working with challenging behaviour and has been tested on a British sample. (See Appendix 5).

Demographic Questionnaire

This included questions related to gender, age, length of service, time in present job and qualification. Smoking, alcohol consumption and personal details such as marital status and number of dependants were also included. Participants were invited to comment on the survey and / or their jobs. (See Appendix 6).

PROCEDURE

Survey questionnaires were distributed to staff members of each team. The covering letter outlined the purpose of the research, explained that all completed questionnaires were confidential and provided the address and telephone number of the researchers if further help was required. (See Appendix 7i). A consent form was also included (see Appendix 7ii). The data were collected within a 2-week period and a time arranged to collect the completed questionnaires, in sealed envelopes.

ETHICAL CONSIDERATIONS

It was considered that completing questionnaires on stress and coping could, potentially, raise issues which were distressing to participants. To accommodate this possibility, participants were reminded of the Health Authority's free counselling scheme for employees and a leaflet outlining the scheme was provided with the questionnaires. (See Appendix 8).

In order to ensure confidentiality, questionnaires were not identifiable either by name or occupational status. All contributions were treated with complete anonymity. Data were held by the researcher and individual responses were not revealed to any other person. Only group differences were reported in the final analyses and in subsequent presentations to the teams. Approval for the study was granted by the University of Wales (Bangor) Ethics Committee. (See Appendix 9).

RESULTS

Hypothesis 1 – stress levels of direct care staff will be significantly higher than the stress levels in the comparison group (all adults administered the GHQ in the Health Survey for England; Bennett et al, 1995). In the current study, 15 out of the 32 participants scored four or more on the GHQ-12, which is accepted as signalling that an individual is likely to be experiencing high levels of distress and mental health problems. On this basis, 46.8% of staff in this study were experiencing high levels of distress compared to 16% in Bennett's survey. A chi-square was performed in order to test the significance of the difference in the two populations. The obtained value was found to be 7.27. Thus the hypothesis was supported.

This higher level of distress is reflected in the higher cigarette and alcohol consumption compared to the general population, NHS staff and staff in a learning disability service. The demographic questionnaire included several items relating to staff outcomes, some of which were comparable with findings from other studies. For the GHQ-12, comparisons were possible with learning disability staff (Staff in Services for People with Learning Disabilities, Hatton et al, 1997), NHS staff (the NHS Workforce Initiative, Borrill, 1996), British employed adults (British Household Panel; cited in Borrill, 1996) and English adults (Health Survey for England, Bennett et al, 1995). For current cigarette and alcohol consumption, data comparisons were possible with both Hatton et al's study (1997) and Bennetts study, (1995). The comparison data is summarised in Table 2, overleaf.

TABLE 2 - STAFF OUTCOMES WITH COMPARISON DATA

	This Study (Direct Care Staff) 1998	Learning Disability Service (1997)	NHS Staff (1996)	Employed Adults UK (1996)	All Adults, England (1995)
Score of 4+	46.8%	32.5%	26.8%	17.8%	16%
Current cigarette smoking					
None	56%	65%			73%
1-9	9.5%	5%			7%
10-19	9.5%	15%			10%
20+	25%	15%			10%
Alcohol consumption MEN - Units per day					
None	10%	17%			16%
Low <3	27%	42%			34%
Moderate 3-4	36%	17%			21%
High >4	27%	24%			30%
WOMEN - Units per day					
None	14%	32%			33%
Low <2	52%	42%			38%
Moderate 2-3	24%	18%			16%
High >3	10%	8%			13%

*Footnote - 1 Unit + 1/2 pint beer or 1 glass wine or 1 measure of spirit. Figures taken from DoH guidelines (1997) on alcohol consumption.

Hypotheses 2 – coping – these hypotheses examined the relationship between coping style and measures of stress; (a) that there would be a statistically significant positive correlation between measures of occupational stress as measured on the OSI, general stress as measured on the GHQ and emotion-focused coping style as measured on the SWC-R (Wishful Thinking sub-scale). The results are summarised in the table 3a below.

Table 3(a) Pearson's R correlation coefficients for emotional-focused coping and stress measures

	General Health Questionnaire	Vocational Strain	Psychological Strain	Intrapersonal Strain
SWC – R Wishful Thinking	.555 **	.801 **	.808 **	.458 **

****p < .01**

It was also hypothesised (b) that emotion-focused coping would have a significant positive correlation with the longer term effects of stress as measured on the MBI. The results are summarised in table 3 (b) below.

Table 3 (b) Pearson's R correlation coefficients for emotion-focused coping and burnout measures

MBI			
	Emotion Exhaustion	Depersonalisation	Personal Accomplishment
SWC – R Wishful Thinking	.652 **	.570 **	-.351 *

***p < .05**

****p < .01**

Thus both hypotheses, a & b were supported.

Hypotheses 3 – occupational roles and stress

- a) That there will be statistically significant positive correlations between aspects of occupational roles as measured on the OSI and stress, as measured on the vocational strain (VS) sub-scale of the OSI and the general stress measure, GHQ. The results are summarised in Table 4 (a) below.

Table 4 (a) Pearson's R correlation coefficients for aspects of occupational roles and measures of stress

	Responsibility	Role Ambiguity	Role Boundary	Role Insufficiency	Role Overload
VS	.088	.617 **	.754 **	.605 **	.156
GHQ	-.039	.337 *	.307 *	.349 *	.221

*p < .05

**p < .01

Thus the hypothesis was supported for role ambiguity, role boundary and role insufficiency.

- b) It was also hypothesised that there would be statistically significant positive correlations between occupational roles and the longer term effects of stress as measured on the MBI. The results are summarised in Table 4 (b) below.

Table 4 (b) Pearson's R correlation coefficients for aspects of occupational roles and measures of burnout

	Responsibility	Role Ambiguity	Role Boundary	Role Insufficiency	Role Overload
MBI Emotional Exhaustion	.051	.564 **	.488 **	.564 **	.368 *
MBI Depersonalisation	.116	.434 *	.543 **	.382 *	.051
MBI Personal Accomplishment	.024	-.167	-.264	-.173	-.119

* p < .05

** p < .01

Thus the hypothesis was supported for role ambiguity, role boundary and role insufficiency.

Hypothesis 4 – staff support and stress

That there would be a statistically significant negative correlation between staff support as measured on the SSQ and stress levels measured on both the GHQ and Vocational Strain (VS) subscale on the OSI. The results are summarised in table 5 (a) below

Table 5 (a) Pearson’s R correlation coefficients for the measure of staff support and measures of stress

	GHQ	VS
SSQ	- .600 **	- .642 **

**** p < .01**

- b) It was also hypothesised that staff support would be significantly negatively correlated with the longer term effects of stress as measured on the MBI. Results can be seen in table 5 (b) below.

Table 5(b) Pearson’s R correlation coefficients for the measures of staff support and burnout

MBI □	Emotional Exhaustion	Depersonalisation	Personal Accomplishment
SSQ	- .662 **	- .471 **	.175

**** p < .01**

Thus both the hypotheses were supported.

Hypothesis 5

Differences between the teams were computed by one-way analyses of variance and post hoc comparisons by Student Newman Kuels.

For stress measures, GHQ and VS, no significant differences were found between the four teams ($F_{3, 31} = 1.524, p = .230$ ns).

Occupational Roles – significant differences were found between the teams on the responsibility sub-scale ($F_{3, 31} = 1.540, p = .225$). Post hoc comparisons revealed that the community team reported significantly more responsibility than the hospital team. All other comparisons were not significant.

Similar results were found on the measure of role overload ($F_{3, 31} = 2.920, p = .0515$). Again, post hoc comparisons revealed the community team reported significantly more overload than the hospital team. All other comparisons were not significant.

For role boundary ($F_{3, 31} = 5.013, p = .006$) and role insufficiency ($F_{3, 31} = 30.035, p = .000$) significant differences were found between the hospital team and all other teams. For role ambiguity, significant differences were found between the community team and both the additional support and emergency intervention teams, ($F_{3, 31} = 5.588, p = .003$) but not significantly different from the hospital team.

On coping and support measures (SWC-R and SSQ), no significant differences between the team were found.

On measures of burnout, no significant differences were found between teams on the depersonalisation or personal accomplishment sub-scales.

The emotional exhaustion sub-scale revealed significant differences between the teams ($F_{3, 31} = 5.817, p = .0032$). Post hoc comparisons revealed that the hospital team were experiencing higher levels of emotional exhaustion than either the additional support and emergency intervention teams, and that levels of emotional exhaustion in the community team were significantly different from those reported by the additional support team. All other comparisons were non-significant.

A summary of results can be seen in table 6 below.

Table 6, summary of results of analysis of variance

Variable	Result	Team's reporting highest means
<u>Stress</u> GHQ and VS	N.S.	-
<u>Occupational Roles</u> Responsibility	$F_{3,31} = 1.540$ $p = .225$	Community
Role Overload	$F_{3,31} = 2.920$ $p = .0515$	Community
Role Boundary	$F_{3,31} = 5.013$ $p = .006$	Hospital
Role Insufficiency	$F_{3,31} = 30.035$ $p = .000$	Hospital
Role Ambiguity	$F_{3,31} = 5.588$ $p = .003$	Community / hospital
<u>Coping</u> SWC-R	N.S.	-
<u>Support</u> SSQ	N.S.	-
<u>Burnout</u> Personal Accomplishment	N.S.	-
De-personalisation	N.S.	-
Emotional Exhaustion	$F_{3,31} = 5.817$ $p = .0032$	Hospital / community

DISCUSSION

The finding that stress levels for the staff under study were statistically significantly higher than comparison groups, confirms previous research (Hatton et al, 1997) Working in a learning disability service is particularly stressful and working with challenging behaviour is likely to be most stressful of all.

One possible reason why the percentage of staff reporting stress levels that were much higher than in other studies, could be that only direct care staff were assessed in the present study. Many other surveys (e.g. Thomson, 1987; Hatton et al, 1997) combine direct care staff, managers, therapists and even domestic and ancillary workers. While having the advantage of increasing the sample size, this practise may under-report stress for those who work directly with clients. Clearly, there may be large differences between all these roles, which could lead to variation of demands and support. In practise, it is more important to know precisely which factors are influencing stress for which staff groups. The present study demonstrates that even in very small teams there exists considerable variance between stressors and outcomes, which could reliably inform managers of potential problem areas and suggest possible intervention strategies.

The finding that emotion focused coping strategies have a significant impact on all measures of stress is a very important one. The results from this study suggest that emotion focused coping strategies (ie, those that involve efforts to either avoid or manage the emotions involved in a stressful event rather than attempting to change the stressful event itself) are an important contributor to levels of distress in direct care staff. High levels of stress were found not only in work settings but also for the life of staff in general, as demonstrated by the highly significant correlations found on the GHQ, and psychological and interpersonal strain measures. This finding supports and confirms previous research (e.g. Hatton and Emerson, 1995). The present research

also examined the relationship between emotion focused coping style and its impact on burnout – the long-term outcome of prolonged stress, and again found very strong associations. Emotional exhaustion, depersonalisation and the personal accomplishment sub-scales were all significantly correlated with the emotion focus coping style. This suggests that direct care staff who utilise emotion based coping strategies, may be at greater risk of experiencing burnout – particularly emotional exhaustion and depersonalisation and, in the long-term feel a reduced sense of personal accomplishment. These findings have important implications for intervention. Stress management programmes may need to focus on coping with workplace stressors and given the pervasive influence of emotion focused coping, training packages that include problem solving and decision-making skills could be particularly useful.

The finding that some aspects of occupational roles are highly correlated to stress and burnout supports previous research (eg, Razza, 1993; Allen et al, 1990). Role ambiguity, role insufficiency and role boundary appear to have a significant impact on both vocational stress, general stress and on the emotional exhaustion sub-scale of the MBI. The present study also found significant differences between the teams on these occupational stressors.

Role ambiguity measures the extent to which priorities, expectations and evaluation criteria are clear to the individual; high scorers are likely to report a poor sense of what they are expected to do, how they should be spending their time and how they will be evaluated. Results of the analysis of variance found that there were significant differences between the community team and the two support teams, with the community team reporting the highest means of role ambiguity. The difference in means between the community and hospital teams was not significant. These differences may reflect both the organisational structure of the community team and

their working practises. The community learning disabilities team consists of employees from both health and social services, but only those employed by the health authority were included in this study because it was felt important that participants should be able to access the authorities counselling service if required. Consequently, the participants of the community team were predominantly community nurses. Community nurses in this team are managed by a team leader (from social services) and a nursing manager. At any time they may also be answerable to another case manager (from either sector) or may be case managers themselves and thus responsible for the management of others. A typical multi-disciplinary team would include a nurse, a social worker, a psychologist, a psychiatrist and possibly members from allied professions, ie speech therapy, physiotherapy. Typical work would include liaison with a client's family, school, residential and work and respite carers. Given the vast array of possible interactions and expectations of managers and other team members, it is perhaps not surprising that the community team report high levels of role ambiguity. In contrast, the two support teams have very clearly defined roles and while being part of multi-disciplinary work, have just one line manager, and thus the potential for ambiguity is much reduced.

Closely associated to role ambiguity is role boundary. Results of this study indicate significant correlations between role boundary and stress, both vocational and general and, in the longer term, burnout. Role boundary can be described as a measure of the extent to which an individual is experiencing conflicting demands and loyalties in the workplace. High scorers may report feeling caught between conflicting demands and factions, they may also report feeling undervalued and not having a stake in the enterprise. Results of the analysis of variance found significant differences between the hospital team and all other teams. There are several possible explanations for this finding. Firstly, it should be made clear that the participants from the hospital team may, so some extent, have been self-selecting. In order to match the numbers in the other teams, only 8 from a possible 16 staff members were requested to complete the

questionnaires. The choice of participation was left to the individuals and it is possible that the most disgruntled staff choose to complete the forms. Other explanations include the organisational culture that often pervades institutions such as hospitals. It is not uncommon to find deeply entrenched cultures with such organisations, which result in an 'us' and 'them' dichotomy. Certainly this was reflected in the comments made by the hospital team; they referred to managers who had no understanding of the day to day work of direct care staff, feelings of being undervalued of being criticised, and of having no opportunity to improve either their working conditions or the quality of life for the residents in their care because of beaurocratic rules and regulations.

Analysis of variance showed that the hospital team also significantly differed from all other teams on the occupational stressor role insufficiency. Role insufficiency can be described, as the extent to which an individual's training, skills and experience are appropriate to job requirement. High scorers may report a poor 'fit' between their skills and the job they are doing, they may also report under-utilisation and lack of recognition. Given the often mundane routine of institutions, it is perhaps not surprising that the hospital team reported the highest means of role insufficiency. Unlike the other teams, their work involves very little variety and frequently includes more domestic / housekeeping duties which perhaps do not adequately match their training and experience.

Role overload was not significantly correlated with either general or vocational stress, but in the longer term may be associated with the emotional exhaustion aspect of burnout. This finding suggests that increased workload may not in itself, cause stress. However, if it is not adequately responded to, or if resources to cope with demands are not available, it may lead to strain in the long term. In the present study, analysis of variance showed significant differences between the community and hospital teams,

with the community team reporting the highest means. Given the working practises of both teams described earlier, this result could be expected. A similar finding for the measure of responsibility was found, once again the community team reported the highest means possibly for the same reasons described above. That responsibility was not significantly correlated to any of the stress or strain measures is interesting as it suggests that responsibility in the workplace does not lead to stress or burnout. In fact, analysis suggests that there may be a negative association between responsibility and general stress and a positive impact on long term feelings of personal accomplishment.

In terms of Selye's model, discussed earlier, responsibility could be viewed as eustress. If correct, this finding could have implications for re-designing work even for those whose occupations by definition are routine and lacking in variety. While it is not possible for all employees to have high levels of responsibility, it may be possible to allow employees the opportunity to manage their work and time more autonomously. This could increase the individual's locus of control and may have a positive impact on feelings of personal accomplishment. A useful extension in this study would be to explore the associations between responsibility and locus of control and include a job satisfaction measure.

The finding that support was significantly negatively correlated to stress, strain and burnout supported previous research (Crawford, 1990). However, these findings need closer exploration; staff support is a somewhat general term and could encompass many different elements. The Staff Support Questionnaire is a useful probing tool but lacks specificity. For example, one sub-scale examines the role of 'supportive people' and within this are included immediate managers and colleagues. Clearly the type of support given by either of these two could be quite different, and perhaps the

distinction between the two should be made clearer. It is likely that colleagues provide more emotional support while managers may provide more technical support. Yet low satisfaction with managerial support and high satisfaction with peer support averages out at a medium satisfaction level, which at face value may seem acceptable if the two are put together. However, this is neither accurate or informative, and may cloud the real issues. Even if regular supervision is in place through individual performance reviews and appraisals, that does not necessarily mean the quality is good. Indeed there is real danger that such mechanisms become little more than tokenistic. Having a list of items to check (such as personal goals, training needs and performance feedback) can easily become pointless if staff believe that nothing useful will come of it. Comments from this study revealed that some staff felt demoralised by the lack of support from their managers and some felt that their managers actively hindered their careers by not allowing them to attend training courses. This may be due to lack of resources, but if that is the case, there seems little point in asking staff to identify their training needs if they are always refused, as it may perpetuate low morale. Another consistent theme was that of negative feedback – many staff reported that feedback was only given when something had gone wrong. Related to this was the availability of managers in times of crisis. A number of staff acknowledged that although they were well versed in policy procedure, there was rarely the opportunity to discuss their feelings and responses around critical incidents. Given the nature of the work this seems a serious omission as most critical incidents are related to risk, often physical. A suggestion from this research would be that all critical incidents should be followed by a de-briefing session as soon as possible. This would decrease the isolation reported by staff and allow such incidents to serve as real learning experiences for the staff and managers.

This study demonstrated the need for instruments which measure staff support to be refined, so that distinctions can be made between peer and managerial support. The inclusion of a team cohesion measure in this study would have enabled more accurate distinctions to be made. Differences found between the teams may be accounted for in a number of ways. Higher means of the emotional exhaustion sub-scale of burnout found in the hospital and community teams may be closely related to the negative aspects of occupational roles reported by those teams. Given that role ambiguity, boundary and insufficiency were found to be most strongly correlated with stress, it is not surprising that the two teams also reported the highest means on the long term strain measure, as continued and prolonged exposure to such stressors would predict more strain over time. As no correlations were found between length of service in learning disabilities, length of time in present job and stress measures, it seems likely that the occupational stressors are the best predictors of stress and strain. Lower reported levels of occupational stressors by the two support teams may be accounted for in two ways; firstly the working practises of the team, whereby they have a clear remit and well-defined roles. These teams also have distinct authority lines, simply, they know what they are supposed to do and who they are answerable to.

The relationship between depersonalisation and personal accomplishment is less clear. Some research suggests that the depersonalisation sub-scale of the MBI is less reliable than the other sub-scales (e.g. Jackson, Schwab and Schuler, 1994), and test – retest reliability coefficients are lower (0.60) compared to the other two sub-scales (0.82 and 0.80). This may account for the lack of significant findings in the present study. The personal accomplishment sub-scale cannot be accounted for in the same way. The reason why reported levels of personal accomplishment remain reasonably high despite the high levels of stress and strain has not been answered by this study, and a useful extension to the research would be to explore this phenomenon in more detail.

Including a social desirability measure such as the Crowne-Marlow Index (1964) may reveal more accurate responses, and a job satisfaction measure may give a clearer indication of how staff perceive personal accomplishment. Both the community and hospital teams had experienced the upheaval of relocation just prior to the start of the research, which may have increased the stress levels for direct staff. However, the variance between the teams on the long term strain measure (the MBI) suggest that this could not be the only difference between them and the two support teams.

The duration of the present study spanned a period of change for all employees with the local health trust. The health trust was undergoing reconfiguration and there was some uncertainty as to the future of learning disabilities as a separate directorate. It is possible that this fact increased the stress levels for all the participants. Callan (1993) has shown that during times of significant change to organisations in strategies and structures, employees can experience high levels of stress as their jobs, responsibilities and roles also change. If the study were to be repeated in a year's time it would be possible to gauge the influence of such a change on staff stress.

LIMITATIONS OF THE STUDY

Although the study indicated strong associations between measures of organisational variables and measures of stress, the correlational design prohibits definition of the direction of those associations. Correlational studies cannot determine cause and effect. While it is intuitively appealing that organisational factors may increase stress, it is also possible that if stress levels are high, the perception of organisational factors may be distorted.

The present study provides little evidence concerning the relative importance of different factors associated with particular staff outcomes. In terms of building models of staff stress, this issue should be addressed. Employing a path analysis approach would enable the identification of factors that are most important on staff outcomes.

Another limitation of the study concerns the possible selection bias of the hospital team. As described earlier, the hospital team had 16 members but only 8 were asked to participate in order to match the numbers in the other teams. The selection of participants was random, in that staff were asked whether they wanted to participate and the first 8 who agreed were given the questionnaires. This method did not exercise enough control by the researcher and could have resulted in only the most stressed staff agreeing to participate. If this did happen, the data from the hospital team could be skewed.

Finally, there are some basic threats to validity associated with a single-method self-report measurement approach. Webb, Campbell, Schwartz, Sechrest and Grove (1981) describe interviews and questionnaires as “a foreign element into the social setting they would describe, they create as well as measure attitudes, they elicit atypical roles and responses, they are limited to those who are accessible and will cooperate”. The use of such methodology in the present study may have influenced the participants’ awareness of the measurement process. As with all survey methodology, responses may be slanted to create impressions based on assumptions about how the data will be used, and could therefore contaminate research results. Employing a multi-method approach, including self-report, physiological and unobtrusive measures could minimise the biasing effect that is present in self-report instruments.

IMPLICATIONS FOR FUTURE RESEARCH

A useful extension to the present study would be to further test the relationship between organisational variables and occupational stress levels. Organisational changes aimed at reducing role boundary, role ambiguity and conflict could be introduced. This might be achieved by clearly delineating role expectations and responsibility and / or increasing levels of staff support. Levels of occupational stress

could subsequently be reassessed to determine whether these changes resulted in significant reductions. This would provide insight into which organisational changes were most effective in reducing stress and burnout.

A similar procedure could be employed with training packages designed to enhance problem focused coping strategies.

Future research on stress levels among staff in learning disabilities would benefit from the standardisation of assessment instruments. It is currently difficult to compare findings from one study to another, since a variety of assessments have been employed. It would be of particular benefit if future research included a specific measure of vocational stress, such as the OSI. At present, general measures of stress such as the GHQ, do not allow the distinction between work stress and other stress to be made clear.

This study has demonstrated the need for more research into peripatetic models of service delivery. Such staff groups have received no attention in the research literature, other than service evaluations or as part of larger surveys. Given the trend towards such models of service delivery and their important contribution to the lives of service users, such research could provide a rich source of information.

The findings of the present study will be presented to each team and recommendations suggested to team managers. Given the variance of findings for each team, such recommendations will be team specific. However, the study has some general implications for the service as a whole.

IMPLICATION FOR INTERVENTION AND TRAINING

Given the high levels of stress found in learning disability services, organisations should conduct regular stress audits of staff. Stress management programmes need to

have an emphasis on workplace stressors. Examining which factors have the most impact on different staff groups would be particularly useful, as it would enable training and intervention to be tailored to the specific needs of each group.

Training packages which include problem solving and decision-making skills could moderate the effects of stress and reduce the utilisation of emotion-focused coping. Services may also need to address the issue of employees control over job tasks and, where possible, increase job variety. Finding ways to reward staff for completion of intrinsically unrewarding task could increase feelings of personal accomplishment, which may reduce stress.

On issues relating to staff support; the provision of both regular supervision and informal contact between managers and direct care staff is important. Regular staff meetings and critical incident sessions should be standard.

In addition to organisations, the present study has implications for policy. Policy makers should consider including evaluations of staff wellbeing in service evaluation research and commission research to implement and evaluate interventions. It would also be useful to identify and disseminate examples of good practise regarding staff in learning disability services.

Role of the Clinical Psychologist

Clinical psychologists working in learning disability services rely heavily on direct care staff, both for information and assistance in carrying out interventions. It is important therefore that psychologists are very aware of the stresses such staff are under in order to minimise the potential for stress created by additional work. Psychologists are also likely to be involved in both stress audits and stress management programmes. It is hoped that research such as this can usefully inform

how assessment and intervention based on the unique stresses faced by direct care staff and their specific working circumstances, can help to improve the wellbeing of staff.

CONCLUSION

In order to reflect current service delivery models for people with learning disabilities, this study sought to examine direct staff in four different support teams in terms of stress, coping and burnout. The findings confirm and extend previous research, in addition to providing specific information regarding the teams under study. Staff stress and associated outcomes are an important topic of study in learning disability services, if staff wellbeing and organisational efficiency are to be improved. More importantly, direct care staff provide the interface through which national and regional policies are translated into action which directly affect the lives of people with learning disabilities. A healthy workforce will work more effectively and efficiently. A commitment to staffing issues will be beneficial to not only the individual but also to the organisation and most beneficial of all to those who depend on learning disability services.

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APPENDIX 4

**THE SHORTENED WAYS OF COPING (REVISED)
QUESTIONNAIRE**

This section concerns how you cope with problems at work. By problems we mean problems with other staff, service users, or anything which you yourself feel to be a problem.

For each statement, please tick the box most appropriate to you.

	Not used	Used somewhat	Used quite a bit	Used a great deal
I daydream or imagine a better time or place than the one I am in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I draw on my past experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think a couple of different solutions to problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wish that I could change how I feel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I try to come out of experiences better than when I went in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wish that I could change what has happened	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I try to analyse the situation in order to understand it better	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually know what has to be done, so I keep up my efforts to make things work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take it out on other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I avoid being with people in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have fantasies or wishes about how things might turn out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I stand my ground and fight for what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wish that the situation would go away or somehow be over with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I make a plan of action and follow it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

APPENDIX 5

THE STAFF SUPPORT QUESTIONNAIRE

STAFF SUPPORT QUESTIONNAIRE

Please read these instructions carefully before completing:

1. Please answer the questions on your own before you talk to other staff about it.
2. Do not put your name on the questionnaire as the results will be compiled to give a group view of staff support needs.
3. The answers you give will be treated as strictly confidential and only the group view of staff support will be shown to others.
4. Remember there are no right or wrong answers - give *your* opinion about *your* support needs.

1. How clear are you about the main objectives you should be working towards in your job?

Very clear	5	4	3	2	1	Very unclear
------------	---	---	---	---	---	--------------

2. How clear are you about what your direct line manager expects from you?

Very clear	5	4	3	2	1	Very unclear
------------	---	---	---	---	---	--------------

3. How clear are you about the limits of your responsibility in your present position ?

Very clear	5	4	3	2	1	Very unclear
------------	---	---	---	---	---	--------------

4. How clear are you about how satisfied your direct line manager is with what you do?

Very clear	5	4	3	2	1	Very unclear
------------	---	---	---	---	---	--------------

5. Is there somebody you can talk to at work if you are experiencing difficulty in your job?

Always	5	4	3	2	1	Never
--------	---	---	---	---	---	-------

How satisfied are you with this?

Very satisfied	5	4	3	2	1	Very dissatisfied
----------------	---	---	---	---	---	-------------------

6. If you were unable to cope with a situation at work, is there anybody you can call on for practical help?

Always	5	4	3	2	1	Never
--------	---	---	---	---	---	-------

How satisfied are you with this?

Very satisfied	5	4	3	2	1	Very dissatisfied
----------------	---	---	---	---	---	-------------------

7. How clearly have personal risk situations been identified at your place of work?
(ie situations that may threaten you personally)

Very clear	5	4	3	2	1	Very unclear
------------	---	---	---	---	---	--------------

How satisfied are you with this?

Very satisfied	5	4	3	2	1	Very dissatisfied
----------------	---	---	---	---	---	-------------------

8. How clear are the procedures about what to do if something goes wrong?

Very clear	5	4	3	2	1	Very unclear
------------	---	---	---	---	---	--------------

How satisfied are you with this?

Very satisfied	5	4	3	2	1	Very dissatisfied
----------------	---	---	---	---	---	-------------------

9. How often do you turn to the following people for support when you are experiencing difficulty at work?

1. *Direct line manager*

Always	5	4	3	2	1	Never
--------	---	---	---	---	---	-------

How satisfied are you with this?

Very satisfied	5	4	3	2	1	Very dissatisfied
----------------	---	---	---	---	---	-------------------

2. *Colleagues*

Always	5	4	3	2	1	Never
--------	---	---	---	---	---	-------

How satisfied are you with this?

Very satisfied	5	4	3	2	1	Very dissatisfied
----------------	---	---	---	---	---	-------------------

3. *Other sources of support*

Yes	1	No	2
If yes, please state who:			

APPENDIX 6

DEMOGRAPHIC QUESTIONNAIRE

ABOUT YOU:

1. Age _____
2. Male / Female
3. Single Married / Living with Partner Separated / Divorced / Widowed
4. Do you have any dependent children living with you? Yes / No
5. Do you have any other dependents living with you? Yes / No
6. On average, how many cigarettes do you smoke per day? _____
7. On average, how many units of alcohol do you drink per day?
(eg, 1 unit = ½ pt lager / beer or 1 glass wine or 1 measure of spirit) _____
8. On average, how many cups of caffeinated coffee/tea/cola do you drink per day? _____
9. Have any major changes happened to you in the last 6 mths
(eg, marriage, moving house, serious illness) Yes / No

ABOUT YOUR JOB:

1. Qualified / Unqualified
2. Length of time in your present job _____ yrs _____ mths
3. Length of time in services for people with learning disabilities _____ yrs _____ mths
4. Do you work shifts? Yes / No
5. Do you ever work extra hours? Yes / No
6. If yes - are these paid Yes / No
- taken as time in lieu Yes / No
7. If you work extra hours, how much notice do you usually get?

Less than 24 hrs	_____
Between 24 hrs - 1 wk	_____
More than 1 wk	_____
8. Can you usually choose whether or not to work the extra hours? Yes / No
9. How many months is it since you had a holiday of at least one week? _____
10. Have you been absent from work because of sickness in the last 6 - 12 mths? Yes / No
11. If yes, how many times? _____
12. How many days in total? _____

APPENDIX 7(i)

COVERING LETTER OUTLINING RESEARCH

**UNIVERSITY OF WALES
BANGOR**

I am a Trainee Clinical Psychologist and am currently carrying out a study assessing stress levels in direct care staff working with people who have a learning disability. I would be grateful if you would read the information sheet attached to this letter to see if you would be willing to participate.

The study has been approved by the University of Wales, Bangor ethics committee and their addresses are provided. The project will be supervised by Prof F C Mace, Academic Director, North Wales Clinical Psychology Course.

University of Wales, Bangor
School of Psychology Ethics Committee
41 College Road
BANGOR
LL57 2DG

Thank you for your consideration

Yours faithfully

Liz Whitehead

STRESS AND LEARNING DISABILITY STAFF INFORMATION SHEET FOR PARTICIPANTS

What is the aim of the project?

The aim of this project is to assess occupational stress and ways of coping among staff who work with people who have a learning disability and challenging behaviour.

How have I been contacted?

We are contacting members of teams working directly with people who have a learning disability in the Gwynedd area and are carrying out this study independently but with the knowledge of your team leader.

What do I have to do?

If you agree to take part, you will be sent a questionnaire to complete. This questionnaire will ask you to think about your work and what aspects are stressful, your views on management, how you cope with stress, and your current emotional and physical health. The questionnaire will take around 40 minutes to complete. Each questionnaire will be treated in strict confidence, it will be ensured that you cannot be identified.

What if I do not wish to take part?

You are under no obligation to take part and are free to choose not to. If you do decide to take part, you are free to withdraw from the study at any time, without having to provide a reason.

Who benefits from this project and how?

By seeming to assess the presence or absence of stress in your work group, it is hoped that this information might be used to change policy and, if required, stress management training might be offered.

THANK YOU FOR TAKING THE TIME TO READ THIS LEAFLET

APPENDIX 7(ii)

CONSENT FORM

CONSENT FORM

The present research project aims to assess if there are any indicators of stress in direct care staff working with people who have a learning disability. It is expected that the questionnaires will identify stress levels and potentially indicate the need for stress management.

The questionnaires will take around 40 minutes to complete, in a time convenient for you.

Some of the materials, if required will be provide in Welsh, however the questionnaires will be in the medium of English.

If you agree to participate, a time will be arranged for me to deliver the questionnaires to you and have them completed. If you have any further questions, please contact me, Liz Whitehead at, NWCPC, 43, College Road, Bangor, LL57 2DG (01248 382205)

I agree to participate in this study. I have been given a copy of this form and the information sheet and had a chance to read through them.

Your Signature:

Date:

Signature of Investigator:

If you have any complaints concerning the conduct of this project, please address these to:

Professor CF Lowe, Head of School, School of Psychology, University of Wales, Bangor, LL57 2DG.

APPENDIX 9

LETTER GRANTING ETHICAL APPROVAL

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c.c. Professor F.C.Mace



February 15, 1999

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Elizabeth Whitehead
Clinical Trainee
North Wales Clinical Psychology Course
University of Wales
Bangor
Gwynedd

Dear Colleague

Stress and Coping in Learning Disability Staff

Your research proposal (referred to above and on the attached sheet) has been reviewed by the School of Psychology Research Ethics Committee and they are satisfied that the research proposed accords with the relevant ethical guidelines.

If you wish to make any substantial modifications to the research project, please inform the committee in writing before proceeding. Please also inform the committee as soon as possible if participants experience any unanticipated harm as a result of taking part in your research.

Good luck with your research.

Kath Chitty
Coordinator - School of Psychology Research Ethics Committee