

Does Working in Rehabilitation Setting is more Stressful than Hospitals?

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ABSTRACT

Clinical work in mental health may be considered stressful for a variety of reasons. This research aimed at studying job stress among mental health professionals working with the mentally ill and their families. The sample comprised of 63 professionals (clinical psychologists, psychiatric social workers, psychosocial rehabilitation professionals, and occupational therapists) working in psychiatric hospitals and various rehabilitation centres in the city of Kolkata. Professionals with a minimum work experience of one year and those currently working in that particular setting were selected, with consent to participate in the study. The researcher designed a socio-demographic data sheet and used a standardized tool, the Mental Health Professionals Stress Scale (MHPSS) consisting of seven subscales, to assess job stress. The data analysis was done through descriptive statistical techniques and comparison in terms of t-test and ANOVA.

Moderate levels of stress are found in both settings, and professionals in psychiatric hospital settings scored more levels of stress than those working in rehabilitation settings. The comparative stress scores on various subscales of the MHPSS for both groups were statistically significant as shown by the 't' test values. Among the seven subscales, "Workload" has higher stress scores than other subscales in both settings. Socio-demographic variables such as age, gender, marital status, educational qualification, residential status, nature of work, and type of setting were statistically significant in both the settings in relation to the subscales as shown by the ANOVA results.

Keywords: Occupational stress, mental health

INTRODUCTION

Stress is a normal, universal human experience and a routine part of our lives. An unavoidable effect of living, it is an especially complex phenomenon in modern technological society. It is a feature of life which can be both protective and harmful. Unfortunately "stress" is too often viewed in a negative context when, in fact, it enables us to cope with change.

A certain amount of stress is beneficial for performance. Good stress or eustress is stress that benefits performance and health; distress on the other hand, is stress that affects these. Protective stress is part of a natural process - when threatened; the body always reacts with the same general adaptive mechanisms. The physical symptoms that occur when we are under stress enable us to "flee" or "fight" the threat. This response is a basic life protecting mechanism, enhancing

physical and mental defences and preparedness - it focuses attention, and mobilizes the energy and resources necessary to be able to take appropriate action. Stress therefore allows us to remain productive even in the face of changing and challenging situations (Connor, 2003).

Too much stress results in a drop in performance, and stress-related problems like inability to concentrate or physical illness. Everyone has an ideal level of stress, but it differs from person to person. Stress reactions are dependent on our personality, our professional experience and our physical and emotional well-being.

When the circumstances inducing the stress are excessive, very intense or continuing over a period of time, stress may begin to negatively affect an individual's personality, health and ability to perform.

Symptoms of stress can be physical and psychological. There could be changes in ordinary behaviour patterns, such as changes in eating habits, decreased personal hygiene, withdrawal from others and prolonged silences. It has been linked to coronary heart disease, psychosomatic disorders, and various other mental and physical problems (Lundberg, 2000).

Depending on its nature, stress can be thought of as cumulative or traumatic:

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Cumulative Stress: Cumulative (or chronic) stress builds up slowly as a result of the magnitude and multiplicity of demands, lengthy working hours and daily frustrations and difficulties of living and working in emergencies. Because stress reactions develop so slowly and imperceptibly it is quite often difficult to notice them in oneself, they are, however, usually noticeable to close colleagues. Once removed from a stressful situation and with the possibility for rest and relaxation, a person generally recovers quickly and may become aware of the difference in how one responds to situations when one is not experiencing stress.

Traumatic Stress: Traumatic stress is brought on by unexpected and emotionally powerful events ("critical incidents") that overwhelm the individual's usual coping abilities. Critical incidents may arise in the context of a major disaster or emergency, and could be, for example, injury or death of a colleague, hostage taking, deaths of children, undergoing great personal risk, being a powerless witness of violence, or seeing or being associated with a tragic event accompanied by intense media coverage (especially if this is inaccurate) (UNHCR, 1996).

Occupational Stress

One of the most significant names associated with the concept of stress in psychology is Hans Selye, who gave the General Adaptation Syndrome. This refers to the total mobilization of the organism's resources and defense systems to meet the situations of severe stress. According to Selye, there are three levels of defense, each determined largely by endocrine secretions-the stages of alarm, resistance, and exhaustion. From that moment on, research into occupational stress began (Shivkumar, 1998).¹⁰

When the optimum level of stress, which varies from person to person, is exceeded, the costs are experienced in the form of health problems and illnesses besides many other consequences. (Mishra, 1999)¹¹. In the modern work environment, physical hazards and demands have been reduced, whereas other forms of stress that are psychological in nature, caused by aspects like a very high work pace, competition, and has considerably increased. These new trends are likely to involve an increased risk of work-related stress due to work overload, role conflicts and lack of time for rest and recovery. (Cushway, Tyler and Nolan, 1996).¹²

Occupational stress in the work place includes relatively enduring or chronic stressors such as role conflict, role ambiguity, role overload, interpersonal conflict with a co-worker, and frequently recurring daily hassles at work, pressures of work such as fear of job loss, blocked ambition or work overload also have an effect on home life. This is particularly relevant for dual career couples or in cases where one partner may be experiencing financial difficulties or life crisis (Cooper, 1997).⁴

There are a variety of factors intrinsic to the job which are potentially stressful and which have been linked to poor physical and mental health. These include poor working conditions, shift work, long hours, travel, risk and danger, person-job mismatch, new technology, and work overload, both

of a qualitative and quantitative in nature. Three critical factors are major sources of potential stress: 1) role ambiguity, 2) role conflict, and 3) the degree of responsibility for others. (Copper, 1997).

Relationship with others at work is potentially stressful. Strong support from peers has been found to relieve job strain whereas mistrust of co-workers is associated with high role ambiguity, poor communication, low job satisfaction, and poor psychological wellbeing. Job insecurity and career development have increasingly become a source of stress during the merger and acquisition boom of the 1980s and still continuing. Sources of stress sometimes are related to the outcome of organisational culture and management style. That may include office politics, lack of participation and effective consultation, restrictions in behaviour and poor communication (Cartwright, et al., 1993).

In India at present, the work situation has undergone profound changes. In the modern work environment, physical hazards and demands have been reduced, whereas psychological stress, caused by a very high work pace, competition, and efficiency and by successive readjustment to organisational changes, has increased (Prakash, 1990).

Most researchers investigating occupational stress have employed measures of psychological strain with either focus on effective response to a stressful demand (such as anxiety) or the respondents' overall attitude to their job satisfaction or psychological "health". The term "burnout" was used by Maslach to define a particular form of job stress found in professional careers. He described it as a response to the emotional strain of dealing with people with problems. Physical and emotional exhaustion, reduced personal accomplishments, low self-esteem and depersonalization are some of the pervasive symptoms of "burnout" (Maslach, et al. 1996).

For women in particular, changes in the work place scenario have been quite dramatic. The number of women in the labour force approaches that of men, while the traditional female responsibility for home and family remains mainly the same. Consequently, stress from work overload and role conflicts has become an increasing problem for many women. Generally, women also report more health problems than men. A likely explanation for these gender differences is that women were unable to unwind and relax due to their greater responsibility for work at home (household chores, child care) (Lundberg, 2000).

Sharma et al, (2004) look at mental health of women in relation to job stress in view of the cultural expectation of women being associated with work in their homes. Recent changes, notably the influence of Western thinking in education, and rapid pace of economic and social development in the country have made it possible for women to work in government as well as private undertakings. But women in modern India face gender differences and insecurity in work place and this in turn causes life stress and burnout.

Occupational stress in mental health

Clinical work in mental health may be considered stressful for a variety of reasons. Meanwhile, day-to-day work demands a more or less empathic relationship with mentally ill patients. The work of mental health professionals involves

intense, intimate interactions with clients over extended periods of time, which often have the potential to arouse strong emotional feelings and are thus a source of stress to the person. It is when these stresses are not acknowledged and adequately dealt with that they may result in burnout (Pines and Maslach, 1978).

While occupational stress has been studied among various vocational groups, there has been little attention paid to health care professionals, mental health professional in particular. It is increasingly accepted that professionals in the mental health field face additional stresses that are unique to the nature of their work (Pottage and Huxley, 1996).

Mental health professionals work in emotionally demanding environments, and are particularly vulnerable to severe emotional exhaustion and psychological tension which are believed to be beyond, and qualitatively different from, other organizational stressors (Moore and Cooper, 1996), and hence merit separate consideration.

Years of work with any kind of chronic illness inflict a lot of burden on not only the caregivers, but on the professional staff who constitute the treatment team. Professional “burn out” is being increasingly documented and strategies have suggested delaying / avoiding this phenomenon. This has been described for not only those who care for chronically ill patients such as those suffering from schizophrenia, AIDS, etc, but also for those working in acute care wards. (Thara, 1997).

The number of dual-career couples in the country is on the rise in recent years. Life stress and burnout among couples in medical profession also studied and being observed that gender differences in life stress, burnout and the life stress burnout-relationship in couples in medical profession is significantly differs. (Pradhan and Mishra, 1995).

In India, there is a huge gap between the number of people affected by psychiatric disorders in need of mental health services and the number of trained people in this field. The gap may be because of shortage of trained manpower, stigma associated with mental illness and professionals working in this area, lack of financial resources, not enough facilities for treatment and rehabilitation, and the magnitude of problems faced.

It is in this background that the current study has been undertaken. This study mainly focuses on the extent of job stress prevailing amongst professionals working with mentally ill persons and their families. Through this, the researcher also seeks to identify some of the job-related factors associated with or contributing to high stress levels in hospitals and in residential psychosocial rehabilitation care settings.

MATERIALS AND METHOD

Objective of the study: The present study was undertaken to find out the degree of stress among mental health professionals (clinical psychologists, psychiatric social workers, psychosocial rehabilitation professionals, occupational therapists) working in psychiatric hospitals and rehabilitation settings, and to compare the stress between these two settings. This would give an idea regarding the extent of stress levels among professionals who

work with mentally ill and what are the various factors which are responsible for it.

Sample of the study: Sample for the study was selected using purposive sampling. The study comprised of professionals (clinical psychologists, psychiatric social workers, psychosocial rehabilitation professionals, and occupational therapists) from hospital settings and rehabilitation settings, working with mentally ill and their families. The data was collected from one government psychiatric hospital, three private hospitals having psychiatric departments, and four voluntary organizations offering rehabilitation facilities for the mentally ill in Kolkata. Written consent was obtained from the participants for the study.

The final sample consisted of 63 respondents from two groups – Group 1 had 30 respondents working in hospital setting (both private and govt. hospitals with psychiatric facilities); Group 2 had 33 respondents from rehabilitation care setting (both residential and non-residential care).

Inclusion criteria:

- Professionals who fulfilled the following criteria were included in the study:
- Staff of agencies (hospitals and rehabilitation settings) offering treatment and care for mentally ill individuals and their families.
- Respondents with a postgraduate degree in psychology, social work, occupational therapy, psychiatric nursing, or psychosocial rehabilitation
- Respondents currently working in the setting with a minimum work experience of one year.

Exclusion criteria:

- Professionals with a past or present history of mental illness and those with a history of mental illness in their family.
- Psychiatrists were not a part of the current study because the nature of their work and consequently their work demands and stresses differ significantly from that of the non-medical mental health professionals.

Tools used:

1. Socio-demographic data sheet.
2. Mental Health Professionals Stress Scale (MHPSS) by Cushway, Tyler, and Nolan (1996)

Socio-demographic Data: The socio-demographic data sheet used for the study collected information pertaining to the respondents such as age, gender, marital status, educational qualification, name of the organization where presently working, designation, duration in service in current job (in years), whether living with family, type of family, and nature of work.

Mental Health Professionals Stress Scale (MHPSS): The tool used in the present study to assess stress among mental health professionals, was developed by Cushway, Tyler, and Nolan (1996). The 42-item Mental Health Professionals Stress Scale (MHPSS) is a standardized tool.

It has the following 7 subscales of occupational stress with 6 items in each subscale:

workload, client-related difficulties, organizational structure and processes, relationship and conflicts with other professionals, lack of resources, professional self-doubt, and home-work conflict.

Each item requires the respondent to indicate the degree of his or her occupational stress on a four-point scale, ranging from 0 to 3 ('0' means "does not apply to me" and '3' is "does apply to me"). It is a self-administered tool and takes about 15 - 20 minutes to complete.

The factor structure and reliability and validity of this scale was examined in the Indian context by Mehrotra, Rao, and Subbakrishna (2000). The authors found that the MPHSS is a reliable and a valid tool to measure sources of stress experienced by mental health professionals.

Method of data collection: Data was collected from September 2005 to November 2005 using the above-mentioned tools, from mental health professionals working in the city of Kolkata. The researcher approached various hospitals and rehabilitation organizations that fulfilled the study criteria, and the final list of agencies was prepared based on permission given for the researcher to conduct the study. The researcher included those respondents who fulfilled the study criteria and were available on the days the researcher went for data collection. The purpose of the study was explained, and informed consent was obtained from all respondents.

Data processing and analysis: The collected data was coded, tabulated and entered in the computer. Data analysis was done using the Systat and SPSS statistical package. Descriptive statistics such as frequency distribution, percentage, mean, and standard deviation were used. "t" test and two-way Analysis of Variance (ANOVA) were used to compare the two respondent groups (professionals from hospital and rehabilitation settings) with regard to stress scores and the influence of socio-demographic variables.

Ethical issues in consideration: Informed consent were taken from the respondents before administering the questionnaires, and the responses obtained were kept confidential and have been used for purpose of the present study only.

RESULTS

Table 1 depicted that more number of professionals are in the age group of 25 to 29 years in both settings. There are more women professionals than men in both settings and 69.8% of the whole sample are women. More than half of the professionals, that is, 54.0% of respondents from both settings, were married. In both the settings all the respondents are postgraduates, while in rehabilitation settings nearly two-thirds had only Master's degree. Nearly two-thirds of the total sample (63.5%) had one to two years of work experience. Majority of the professionals from both settings (88.9%) belong to nuclear families. More than half of the professionals, that is, 58.7% were living with the family from both the settings. Data relating to the nature of work shows 74.6% of all professionals described their work as "clinical" responsibilities.

Table 2 observed that in all the subscales, more stress is reported by professionals in hospital settings than by those in rehabilitation settings. The "t" test scores for both groups are significant for six subscales of the MHPSS (P value of less than 0.05), except for the subscale "Professional self-doubt".

From table 3; the subscale "Relationship and conflicts with other professionals" was statistically significant for the type of setting in relation to age. All the 7 subscales were statistically significant in both the settings in relation to gender.

The subscale "Relationship and conflicts with other professionals" is statistically more significant than all other subscales in relation to gender.

As regards marital status, the subscales- "Workload", "Client-related difficulties", "Organizational structure and processes", "Relationship and conflicts with other professionals", and "Home-work conflict" were statistically significant in both the settings.

In relation with educational qualification, 5 subscales "Workload", "Client-related difficulties", "Organizational structure and processes", "Relationship and conflicts with other professionals" and "Home-work conflict" were statistically significant in both the settings.

Residential status (currently living with the family) was statistically significant in both the settings in relation to 6 subscales - "Workload", "Client-related difficulties", "Organizational structure and processes", "Relationship and conflicts with other professionals", "Lack of resources" and "Home-work conflict".

Subscales "Organizational structure and processes", "Relationship and conflicts with other professionals", "Professional self-doubt", and "Home-work conflict" were statistically significant in both the settings in relation to the nature of work of the professionals.

DISCUSSION

The current study explores occupational stress with specific reference to professionals working in the area of mental health. Workplace stress can be caused by the nature of the job itself, the role demands, the career profile and requirements, the organizational structure, work climate, and some aspects of the job spilling over in to family life. Here the researcher has tried to focus on the extent of job stress prevailing amongst professionals working with mentally ill persons. The study has sought to look at differences in job stress among mental health professionals due to different work setting like psychiatric hospitals and rehabilitation centres, and also to identify the influence of the socio-demographic variables on job stress.

The findings of this study are similar to those of Mehrotra et al, (2000). Their study examined the factor structure of the MHPSS in 116 clinical psychologists in Indian setting, three items were reported as sources of stress by more than 75 percent of the sample. These were "Too much work to do", "Too many different things to do", and "Keeping professional/clinical skills up to date". In their study two subscales namely "Workload" which resulted in longer working hours and cut into personal

Table1: Socio-demographic profile of the study participants

Socio-demographic variables	Hospital setting		Rehabilitation setting		Total	
	No.	%	No.	%	No.	%
Age (in years)						
<25	5	16.7	4	12.1	9	14.3
25-29	13	43.3	16	48.5	29	46.0
30-34	4	13.3	4	12.1	8	12.7
35-39	5	16.7	5	15.2	10	15.9
40-44	1	3.3	1	3.0	2	3.2
45-49	0	0.0	3	10.0	3	4.7
50-54	2	6.7	0	0.0	2	3.2
GENDER						
Men	5	16.7	14	42.4	19	30.2
Women	25	83.3	19	57.6	44	69.8
Marital status						
Single	14	46.7	15	45.5	29	46.0
Married	16	53.3	18	54.5	34	54.0
Educational Qualification						
PhD	7	23.3	5	15.1	12	19.1
M. Phil	12	40.0	5	15.2	17	26.9
Master's degree	11	36.7	23	69.7	34	54.0
Duration of service						
1 to 2 years	22	73.3	18	54.5	40	63.5
3 to 4 years	4	13.3	6	18.2	10	15.9
5 to 6 years	2	6.8	3	9.1	5	7.9
7 to 8 years	-	-	3	9.1	3	4.7
9 to 10 years	1	3.3	-	-	1	1.6
11 years and above	1	3.3	3	9.1	4	6.4
TYPE OF FAMILY						
Nuclear	23	86.7	30	90.9	56	88.9
Extended	3	10	2	6.0	5	7.9
Joint	1	3.3	1	3.0	2	3.2
Residential status (Living with the family)						
Yes	17	56.7	20	60.6	37	58.7
No	13	43.3	13	39.4	26	41.3
Nature of work						
Clinical	22	73.3	25	75.7	47	74.6
Teaching/training/admin/research	8	26.7	8	24.3	16	25.4
Total	30	100.0	33	100.0	63	100.0

Table-2: Comparative stress scores in various subscales for both settings

Subscales	Hospital setting		Rehabilitation setting		't' value	P value
	Mean	S.D	Mean	S.D		
Workload	8.03	4.59	5.06	3.60	2.87	< 0.05
Client-related difficulties	5.60	3.10	4.06	2.25	2.27	< 0.05
Organizational structure & processes	5.33	4.05	2.79	2.92	2.88	< 0.05
Relationship and conflicts	5.33	3.59	2.57	2.20	3.36	< 0.05
Lack of resources	4.47	3.73	2.82	2.81	2.0	< 0.05
Professional self-doubt	4.60	3.37	3.39	2.29	1.68	> 0.05
Home-work conflict	5.17	4.20	2.49	2.12	3.24	< 0.05

Table-3: Summary of ANOVA results which are statistically significant

Variables analyzed	“F” ratio	P value
Subscale “Relationship and conflicts with other professionals” with “Age” and between “Type of setting”	4.3	< 0.05
“Gender” with subscale “Workload” and with “Type of setting”	4.12	< 0.05
“Gender” with subscale “Client-related difficulties” with “Type of setting”	4.94	< 0.05
“Gender” with subscale “Organizational structure and processes” with “Type of setting”	5.52	< 0.05
“Gender” with subscale “Relationship and conflicts with other professionals” with “Type of setting”	9.00	< 0.05
“Gender” with subscale “Lack of resources” with “Type of setting”	4.61	< 0.05
“Gender” with subscale “Professional self-doubt” with “Type of setting”	3.037	< 0.05
“Gender” with subscale “Home-work conflict” with “Type of setting”	4.46	< 0.05
“Marital status” with subscale “Workload” with “Type of setting”	11.32	< 0.05
“Marital status” with subscale “Client-related difficulties” with “Type of setting”	5.45	< 0.05
“Marital status” with subscale “Organizational structure and processes” with “Type of setting”	8.21	< 0.05
“Marital status” with subscale “Relationship and conflicts with other professionals” with “Type of setting”	11.19	< 0.05
“Marital status” with subscale “Home-work conflict” with “Type of setting”	10.94	< 0.05
“Educational Qualification” with subscale “Workload” in “Type of setting”	5.87	< 0.05
“Educational Qualification” with subscale “Client-related difficulties” in “Type of setting”	3.56	< 0.05
“Educational Qualification” with subscale “Organizational structure and processes” and “Type of setting”	5.59	< 0.05
“Educational Qualification” with subscale “Relationship & conflicts with other professionals”, “Type of setting”	10.47	< 0.05
“Educational Qualification” with subscale “Home-work conflict” and “Type of setting”	7.25	< 0.05
“Residential status” with subscale “Workload” and “Type of setting”	11.35	< 0.05
“Residential status” with subscale “Client-related difficulties” and “Type of setting”	5.51	< 0.05
“Residential status” with subscale “Organizational structure and processes” in “Type of setting”	7.85	< 0.05
“Residential status” with subscale “Relationship and conflicts with other professionals” and “Type of setting”	9.88	< 0.05
“Residential status” with subscale “Lack of resources” in “Type of setting”	4.85	< 0.05
“Residential status” with subscale “Home-work conflict” and “Type of setting”	12.16	< 0.05
“Nature of work” with subscale “Organizational structure and processes” and “Type of setting”	4.42	< 0.05
“Nature of work” with subscale “Relationship and conflicts with other professionals” and “Type of setting”	4.64	< 0.05
“Nature of work” with subscale “Professional self-doubt” with “Type of setting”	4.31	< 0.05
“Nature of work” with subscale “Home-work conflict” and “Type of setting”	6.22	< 0.05

and family time, and “Client-related difficulties” implying a greater emotional strain, emerged as important sources of job stress.

Stress scores in the current study also show “Workload” to be a significant source of stress identified by most respondents, especially hospital staff. Socio-demographic variables such as gender, marital status, educational qualification, and residential status of professionals in both the settings, were found to be statistically significant in relation to “Workload”.

Cushway and Tyler (1996) in their study identified “Professional self-doubt” as the most important source of stress for clinical psychologists, whereas the major source of stress for mental health nurses was found to be the difficulty of handling potentially violent or difficult patients in the context of scarce staff resources. Their results also showed the subscale “Organizational structure and processes” were associated with lower job satisfaction.

In the current study however, the results are different. “Workload” (mean score of 6.3 for both settings) is clearly the most important source of job stress identified by respondents from both settings. The researcher feels that one of the reasons for high workload may be the non-availability of mental health professionals in this field. Work with the mentally ill and their families is long-term, given the chronic nature of severe psychiatric illnesses. This also may be a factor that increases workload on already overworked professionals.

“Organizational structure and processes” was the second highest in terms of the total mean score for both settings (mean score of 4.6), followed by “Professional self-doubt” (mean score of 4.4). ANOVA for variables such as gender, marital status, educational qualification, residential status and nature of work, for professionals in both the settings, were statistically significant in relation to subscale “Organizational structure and processes”.

Authors such as Cushway and Tyler (1994) and Brody (2006) cite workload as a key component of job stress for personnel in the mental health field. The findings of the current study support this, as, across both settings, "Workload" is the highest scoring subscale. The reasons for workload being cited as a source of stress can be understood in the context of existing mental health facilities in the country. Professionals and resources (human, physical, as well as financial) are scarce, and the existing facilities and personnel are overworked.

Therapy is one of the areas of clinical work that professionals engage in. Various elements in therapy are referred to by authors as sources of stress among psychotherapists. For instance, amongst other factors of stress, Hellmann, Morrison and Abramowitz (1987) identified five stress factors associated with the therapeutic role for psychotherapists working in the private and public sectors: maintaining the therapeutic relationship, scheduling, professional doubt, and work over-involvement and personal depletion. Burnout has also been described among psychotherapists. In the current study, however, subscale "Client-related difficulties" ranks as the lowest among stress scores as seen by the mean stress score of 4.0 for both settings. The difference may be because of the cultural context of the study, and also in the manner in which psychotherapy is practiced in these settings.

In the present study, it is seen that in hospital settings the professionals have consistently reported higher stress scores across all domains of the MHPSS. This may be due to the fact that the organizational structure and processes and lack of resources could be the sources of stress. This is similar to the findings highlighted by Latha (2004) with regard to the negative clinical environmental factors. It is assumed by this author that negative environmental factors impinge on the clinicians and result in negative client-clinician interaction and outcome, thereby becoming sources or potential sources of job stress. Negative effects on the clinical environment are factors such as stress, job dissatisfaction and burnout. The same can perhaps be relevant to psychiatric hospitals in the current study.

Collins and Jones (2000) concluded that "pressure and stress should not be seen primarily as individual problems, but as a product of interactions at team, department and institutional levels, and at the home/work interface". In the current study, though these areas were not cited by respondents as significant sources of stress, these aspects of work culture definitely play a role in the kind of setting one works in.

Accordingly, one of the explanations we can seek for the consistently higher stress reported by hospital-based professionals could be the way in which work is organized in psychiatric hospitals. These are, by and large, institutions which follow a largely medical model, and the respondents of the study have been non-medical mental health professionals. Hence factors in the work environment like the multidisciplinary team, organisational structure and processes, relationship and conflict with other professionals can be seen as stressful aspects of the job for non-medical mental health professionals.

Findings of the current study are similar to those in a WHO (1994) study which looked at job satisfaction, occupational burnout and general health in a sample of 123 mental health care professionals in a hospital setting. Some of the sources of stress identified in the study can be applicable to the current sample of hospital-based respondents.

The present study showed that there was a significant difference in the levels of stress reported by professionals in psychiatric hospitals and those working in rehabilitation settings. This finding is in contrast with the study by Prosser et al (1996) who compared stress and job satisfaction between community-based and hospital mental health staff. The overall results showed that community-based staff had significantly higher scores on both the health outcome as well as burnout measures, specifically the emotional exhaustion component.

Prosser et al., (1999) found that job dissatisfaction, and consequently, stress levels were higher among social workers than other professionals in community mental health teams. They attribute this to social workers' dissatisfaction as a consequence of their more marginal position within the multi-disciplinary team, and that the social workers might lose their professional identity as a result of 'role blurring' with health professionals. These factors might be similar for hospital-based professionals in the current study, not only social workers, and hence the higher stress scores reported by professionals (non-medical) in psychiatric hospitals.

Limitations of the study:

- The small size of the sample was one of the limitations in the study.
- The sample consisted of only non-medical mental health professionals. Psychiatrists were not part of the sample.
- The sample profile of this study may not be a representative one.
- This study mainly concentrated on a particular category of postgraduates who work with the mentally ill. The findings are therefore limited only to this group, while in reality, there may be very few agencies especially in rehabilitation settings that have this staff profile.
- The sample included respondents from Kolkata only. This again limits the generalisability of the study findings.

CONCLUSION

The current study was taken up to study job stress amongst professionals working with the mentally ill in psychiatric hospitals and rehabilitation centres. The sample consisted of 63 respondents in total from psychiatric hospitals (30 professionals) as well as rehabilitation settings (33 professionals). The tool used for studying job stress was the Mental Health Professionals Stress Scale (MHPSS), which is a 42-item self-administered questionnaire, with seven subscales. The following are main findings of the study:

It is seen that in all the subscales, comparatively more stress is reported by respondents working in psychiatric hospitals than those working in rehabilitation settings.

The comparative stress scores on various subscales of the MHPSS for both groups were statistically significant.

It is also seen that scores on the subscale “Workload” is comparatively higher than the other subscales in both settings. The second highest stress scores are in the subscale “Organizational structure and processes” for both settings

Socio-demographic variables such as age, gender, marital status, educational qualification, residential status, nature of work, and type of setting were statistically significant in both the settings in relation to the subscales as shown by the ANOVA results.

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