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WORKERS' USE OF PEER RELATIONS TO DEAL WITH STRESS AT WORK
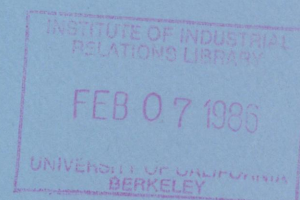
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ABSTRACT

Data are presented on the use of social resources at work to reduce
the negative effects of perceived job stress on the health of ancillary
nursing staff who care for severely and profoundly retarded residents of a
state institution. Sources of job stress were found to stem not from
problems associated with the care of the institutionalized retarded but
rather from staff members' inability to control other critical aspects of
their work. Staff who were part of work-based social networks that they
considered supportive were in significantly better health than those who
were not.

INTRODUCTION

Increasing attention has recently focused on the impact of job stress on human service professionals such as nurses (e.g., Cherniss 1980a, 1980b, 1981; Cherniss et al. 1976; Fimian 1980; Miller and Potter 1982; Pagel and Price 1980; Skinner 1980; Weiskopf 1980). Although little of this work has looked directly at the relationship between job stress and poor physical or mental health, the research has shown that emotional exhaustion, low morale, helplessness, hopelessness, and other forms of frustration contribute importantly to the alarmingly high rates of job dissatisfaction, turnover, and early retirement that plague these fields (Fawzy et al. 1983; Yee 1981; Cook and Mandrillo 1982; Greenberg and Valletutti 1980; Scully 1980; Holsclaw 1965; Storlie 1979). Yet, studies of the effects of job stress on human service paraprofessionals such as ancillary nursing staff appear to be nonexistent (Numerof and Abrams 1984). This is surprising since turnover rates are often far higher among ancillary personnel than they are among nurses (Larkin et al. 1982; Pecarchik and Nelson 1973; Weisman et al. 1981; Winston 1981; Zaharia and Baumeister 1978), and anecdotal accounts reveal job stress to be an important source of job dissatisfaction for these staff as well (Calhoun 1980; Hanavan 1980). It is, consequently, unknown whether the conditions nurses find stressful are similarly perceived by ancillary personnel, or whether the restricted mobility ancillary staff face represents far greater source of dissatisfaction and frustration.

This account will, therefore, present data from a pilot study that sought to identify the sources of work stress experienced by psychiatric technicians who care for the institutionalized mentally retarded and to investigate the links between perceived job stress and

poor health in those staff. Psychiatric technicians (or psych techs) are ancillary personnel who administer nursing care to California's hospitalized mentally ill and mentally retarded. The role of work based social supports in limiting the negative effects of job stress on psych techs' health was also considered. A small but consistent body of research has shown that the presence of social supports at work can reduce job stress and lead to better health (House 1981). Although no research has as yet looked specifically at the relationship between job stress, social support and health in nurses or ancillary personnel, Steffen's (1980) survey of stress among intensive care unit (ICU) nurses found that interpersonal relationships were the most frequently reported source of stress, and the second most frequently reported source of satisfaction. These findings are similar to the results of other studies which have shown that interpersonal ties can be both stress reducing and stress enhancing (Suls 1982; Lazarus and Folkman 1984).

Yet, aside from these and other scattered findings (e.g. Pines 1983, Waldron 1980, Jacobson 1974), studies of the significance of job-based interpersonal ties are rare. Also rare is research in which nurses, or other workers, describe in their own words the work conditions they perceive to be stressful, how stressful work conditions make them feel, and what, for them, are the most effective means of dealing with stress at work (Marshall 1980:25; Rose and Levin 1979:11). We, therefore, undertook a descriptive study of the relationship between work stress, social supports, and health in ancillary nursing staff who work in a state institution. We hypothesized that staff who were integrated into work-based social networks that they felt were supportive would experience better health than those who were not.

BACKGROUND

Southern California Hospital (a pseudonym) is a state residential facility that provides care for the severely and profoundly mentally retarded. Eighty-four percent of the hospital's 1100 resident patients are over 18 years of age; 58 percent of them are male. The IQs of 99 percent of the residents are below 50, 75 percent are below 14, and 50 percent are below 9. Many have other physical and behavioral problems as well. They require total supervision by staff at all times. Most must be dressed, fed, and toileted several times a day. They are typically nonverbal; a great many are nonambulatory; some have multiple handicaps, multiple chronic medical conditions, or are prone to seizures, aggressive, self-abusive or self-mutilatory behaviors. The likelihood that their disabilities will lessen is remote; their potential for learning is ordinarily quite limited. These factors lead to a conventional view that work with the severely and profoundly mentally retarded would be extremely stressful to those who provide the care, a view our data, however, failed to support.

Resident patients are assigned to one of seven treatment programs based on their developmental and medical needs. Units are staffed by between 25 and 30 workers who are trained as psychiatric technicians (PTs), prelicensed psychiatric technicians (PLPTs), psychiatric technician trainees, licensed vocational nurses (LVNs), and registered nurses (RNs). Psych techs are responsible for overall nursing care and supervision of residents including the administration of medications and treatments, observation of residents' condition and behavior, vital signs, charting, grooming, habit training, first aid and the like. Each program is also served by a varying number of staff, including teachers, rehabilitation

therapists, and social workers. The hospital maintains a total staff of about 1,700, approximately 1,100 of whom have direct patient care responsibilities. The facility has all of the characteristics typical of a total institution (Goffman 1961).

METHOD

The High Functioning Program (hereafter referred to as Program HF) was chosen because informal interviews with several administrators and staff revealed that work on that program was considered especially stressful because of the unpredictable and often violent character of its residents' behavior. Data were collected between February and May, 1984, through participant observation, in-depth interviewing, and a self-administered health questionnaire. Participant observation (Pelto and Pelto 1978) was conducted on four of Program HF's five units approximately twice a week for one to two hours during a three-and-a-half-month period. Each unit had its own participant observer. Participant observation data were collected in different parts of each unit and at various times of the day and evening so that the range of psych techs' work experiences would be better understood. Field notes were recorded away from the field site immediately after each observational session.

After three months on the units, interviewing commenced. Twenty-one interviews with day shift staff were conducted: 13 with psych techs, 3 with shift charges, 2 with unit supervisor, 1 with a developmental specialist, and 2 with med techs (psych techs who dispense medications).[1] This represents 51 percent of the day shift on these four units. Twelve of those interviewed were women. Four other staff members were approached, but refused to be interviewed. Seven of the interviews were taped and

later transcribed; the remaining 14 were recorded by hand as the interview was conducted. Interviews ranged in length from 30 minutes to two-and-a-half hours (mean = one-and-a-half hours). Questions were asked about sociodemographic background; sources of perceived stress and satisfaction at work; and the use of social supports on and off the job. Additionally, all of those interviewed filled out a Social Network Map which allowed them to visually represent the nature and intensity of their social relationships with coworkers. Health data were collected using the Cornell Medical Index (CMI) (Brodman et al. 1949). The CMI has been shown to be a valid and reliable instrument for obtaining comprehensive data about a person's physical and emotional state. It consists of 195 questions concerning bodily symptoms, past illnesses, family history, and behavior, mood, and feeling. Each person interviewed completed the CMI. Five additional staff who were not interviewed also completed the CMI. Of 29 CMI questionnaires given out, 26 were returned.

At the conclusion of the data collection period, a coding system was developed for filing and cross referencing the observational and interview data. Coding categories were developed using a modified form of the HRAF Handbook for Coding Cross Cultural Materials (Murdock et al. 1971) and content analysis performed to determine patterns and trends. The categories themselves were developed after several readings of the descriptive data by the entire research team established the relevant classifications. Data were then coded by the field worker who collected them, and cross checked by another field worker for reliability. The CMI data were analyzed according to the CMI Manual.

SOURCES OF SATISFACTION AND STRESS AT WORK

Based on interviews with administrators, conventional wisdom, and a small literature (Sarata 1974, Fimiah 1984) it had been the researchers' expectation had been that the severely and profoundly retarded residents would be responsible for a significant proportion of the job stress techs report. Instead, techs consistently indicate that their most important and valued source of job satisfaction is the residents. They feel pride and a sense of accomplishment when they see progress in residents' social or intellectual development, such as greater independence in feeding behavior or the development of clearer verbal skills. Techs also enjoy planning and participating in special activities for residents such as field trips, monthly dances, and holiday entertainment programs. Several said they experienced strong feelings of personal satisfaction simply from direct interaction with the residents; others said they preferred interaction with them to their fellow staff. Most became psychiatric technicians because they wished to work with the handicapped. Opportunities to do so continue to be the most rewarding aspect of their work.

The sources of stress that techs most often report stem not from the residents but rather from techs' inability to control critical aspects of their work. This is similar to the results of many other studies a variety of occupational groups. These studies show that workers feel stressed and experience worse health when they lack opportunities to participate in decision making pertaining to their jobs or when they have no control over their work (Cherniss and Egnatios 1978; Frankenhaeuser 1981; Gardell 1982; Hamburg et al. 1982; Kahn et al. 1981; Kasl 1978; Stellman 1977).

Feelings of lack of control were manifested during interviews when techs reported they felt misinformed about changes in hospital policies and

procedures because these changes must pass down a multileveled hierarchy before they reach the techs themselves. Techs also feel they lack the means to influence the type and amount of communication they have with hospital administrators, and that their opinions go unheard because there are no channels for these opinions to be communicated. In the words of one psych tech, "The number one stressor here is dealing with the so-called normal people...There is no control whatsoever. They say, 'This is the way it should be done. Do it!'..." The specific sources of work stress psych techs most often report stemming from lack of control are: conflicts over the planning and implementaion of behavior programs; the inability to influence the prescribing of medications; the excessive and seemingly needless quantities of paperwork; the way work is scheduled; and the unpredictability of residents' violent outbreaks. Each of these themes will be discussed below. Because both sources of satisfaction and stress did not vary significantly across the four units studied, comments will refer to all four units (hereafter pseudonymously referred to as Units A, B, C, and D) unless otherwise indicated.

Behavior programming. Although psych techs are required to carry out residents' behavior programs, they resent the fact that psychologists unilaterally originate the plans, and that the plans are often unrealistic as a result (cf. Taylor and Bogdan 1984). One tech who unsuccessfully attempted to become more involved with the development of behavior programs said, "I think one thing they [psychologists] could do is be more assistive (sic) in the way they help you with programming. You tell them your ideas for approaching a problem and they say, 'Okay, why don't you write it up.' So you go to all this trouble, and then they say, 'No, this isn't what we

want to do.' So you've spent two or three days writing up this three-page program, and they tell you this. So you've still got to write it over and, to me, that's troublesome."

Techs further resent the fact that their own knowledge and practical experience with the residents is neither acknowledged nor drawn upon because they lack professional credentials. To them, the behavior programs psychologists design often seem like a theoretical exercise alone. Said one, "Lots of times, they've never even worked with retarded children, and they come here and set up all these programs and they're really not practical." Thus, although psych techs are responsible for the implementation of the programs, they contribute little to their initiation, modification, and implementation. Such frustrations are a fundamental way that technicians experience a lack of control over their work.

Scheduling. The way that techs' schedules are planned, and the procedures for requesting time off are also ongoing sources of frustration. In the past, techs on each unit decided when they would have vacations, take time off, and who would cover when someone was sick or injured. Now these decisions are made by the Program Director, or his assistant. Staff are thus powerless not only to determine their own schedules, but where they will work each shift. Hospital rules require at least five techs to be present on a unit at all times. If too many people call in sick, the Program Director or Program Assistant determines who from another unit will "float" for the absent staff member(s).

Floating is stressful for all who are affected. The floater must work with residents who are unfamiliar to her or him. Their potential for violence is unknown. Also, the floater's unit must reassign duties. Techs prefer not to have to float for only a day or two because the adjustment is

too difficult for all concerned. However, although floating for a longer period is preferable, techs then become concerned about the effects of their long absences on their own residents. For the unit to which the floater is assigned, having someone who is inexperienced with their own residents can also put strain on the staff. "Sometimes we have to work with a floater who isn't carrying his own load of work because it's an unfamiliar unit. Regular staff then have to give added attention to watch out for the floater." This adds to the psych techs workload and is further frustrating because the technicians feel they are not providing their own residents with someone the residents have learned to trust.

Techs are also unhappy about the fact that all requests for time off must be made far in advance, so that when the job stresses become temporarily unbearable, they cannot easily use the time off they have already earned. Vacations must be requested in January for the following year. Cumulative time off (CTO) requests must be made at least two weeks beforehand. Furthermore, CTO requests are often denied because techs are told that there is not sufficient staff available to permit a CTO request to be granted for the period requested. Some techs feels they are penalized for being responsible by coming to work. They resent coworkers whose frequent absences result in greater rigidity in their own schedules.

Paperwork. Program HF techs strongly feel that the amount of time they spend doing paperwork adds fundamentally to the stresses of their jobs. For some, this is because paperwork demands take away time they could instead spend with residents, and so they feel torn by conflicting obligations. For others, it is not simply the time spent in paperwork that bothers them, but the quantity, repetition, disorganization, and lack of

adequate training to handle the multitudes of forms. For seemingly every action that takes place on the unit involving a resident, there are reports to make to supervisors, to the next shift, or both; notes to take on behaviors; and progress sheets to complete. Much additional information must also be charted in several different files, adding to the burden. Techs report that there are now so many different ways that data are recorded in residents' charts that it is often impossible to find a particular piece of information when it is needed. The constant flow of memos about new, ostensibly simplified charting procedures also adds to, rather than reduces, techs' work. Although the new procedures were instituted by the administration in the interest of reducing the amount of redundant recording, hospital auditors find this system unacceptable, so that techs are now required to use both the old system and the new, effectively doubling their work.

Medications. The hospital wide policy which mandates progressive reduction in the overall use of psychotropic medications is a particularly frustrating source of job stress for Program HF psych techs because they work with the hospital's most aggressive residents. They feel that those who established this policy are not aware of the medication needs for the hospital's most aggressive residents because they do not work with them every day. Now techs say they have no alternative but to use harsher means of physical restraint when violent incidents occur because their access to chemical means of restraint is restricted. Yet, it is not the medication policy itself that techs object to; it is the fact that they are required to implement it having played no role in its creation. This is another way that techs' extensive "hands-on" experience with the residents is minimized or ignored. "Administrators feel it's cheaper to pay for psych techs than

for psychotropics," one psych tech bitterly explained . This is yet another way that techs experience powerlessness in dealing with the institution.

Violent Outbreaks. Program HF psych techs are themselves regularly the victims of assaults by residents. On the most violent of the four units studied, there were several violent incidents each day; on the least violent, there was an incident perhaps every two weeks. Techs get bitten, hit, hair pulled, dragged to the floor, have objects thrown at them, or get hurt as they intervene when a resident assaults another resident or member of the staff. Occasionally, the assaults are severe enough as to break techs' (or residents') bones. Some residents also manipulate others with their unpredictable potential for violence because they know they are feared by both residents and staff. Others stalk certain staff members and hit and bite only them. Some techs also describe patterned cycles when residents are completely out of control. These cycles can be specific to a particular resident or group of residents, or a more widespread pattern that affects all the residents on a unit.

Violent outbreaks are the only aspect of psych techs' direct care responsibilities that they consider stressful. This is not only because techs fear being injured by residents, but also because they worry that coworkers will not rescue them when they are attacked. Some techs accuse others of "disappearing intentionally" during outbreaks in order not to get hurt themselves. The inability to depend on coworkers in times of critical need is an important source of tension on some of the units, as will be discussed below. It is another way that techs feel powerless at work, but also one that breeds resentment among coworkers and has the potential for jeopardizing the ability of an entire unit to function effectively.

PSYCH TECHS' USE OF SOCIAL RESOURCES AT WORK

Data on social support were obtained through interviews and observations. Rather than using our own definition of social support and attempting to assess the extent to which techs measured up to this standard, we let the techs themselves tell us what was important to them about their social ties at work, and the extent to which they got from their coworkers the types of support they felt they needed. Unlike staff views on sources of job stress, which varied little across the four units studied, significant variation in techs' definitions of social support and their expectations from coworkers was found. The following discussion describes the social environments on the four units. The units are discussed from most to least cohesive socially.

Unit A. Social support on Unit A, the most cohesive of the four, is shown primarily through helping one another on the job, talking with one another, and friendship. They feel teamwork is essential to a smoothly functioning unit, and they assist one another when called upon or when they see that someone needs help. For example, whenever residents "act out" techs always drop personal grievances and work together as a team to gain control over the situation. "We can count on support from the people around us...It won't work if we're having a war." With regard to less critical situations, however, techs do not always meet their goal of functioning as a team. "Sometimes people 'forget' their duties and pass the responsibility. Like they 'disappear' if they're supposed to groom some clients or escort them to the workshop." Nevertheless, the team model is the one all techs on the unit value in theory, and they know that in emergency situations their coworkers will be there. Some also feel a direct link between their ability to count on their coworkers and their

ability to cope with job stress. One put it concisely when she said, "I
don't usually feel stress as long as I can take five minutes away from what
I'm doing. That way I can maintain control. It's real easy to get away
when you need to here. The staff are real good about it. They encourage
me to walk it off."

Social support is defined more broadly on Unit A than on the other
three units, for all techs here also see it as talking with one another on
the job. Work related matters are routinely discussed on Unit A by all
techs as a group. There is also abundant informal conversation on topics
ranging from personal problems to more casual concerns. Ongoing jokes
about residents, one another, or themselves, are also prominent in daily
interaction. Techs say this helps relieve the tension, "We pull together
as a unit and keep a sense of humor. This helps keep down frustrations."

All Unit A staff maintain casual friendships with coworkers and attend
unit parties on special occasions. Sometimes small groups get together for
drinks or dinners as well. A three person clique meets outside of work
almost daily. These women regard each other as primary friends, both on
and off the job. Most of the techs on this unit have worked together for
several years, and they agree about how the unit should be run. They also
feel theirs is superior to other units, both in their program and in the
hospital as a whole. This unit, however, also regards itself as rather
closed. They prefer not to have to work with outsiders who may have
different ideas than they, and newcomers may suffer as a result.

Most techs on Unit A describe their supervisor as very supportive,
easy to talk to, and resourceful. Said one tech, "If I have a problem I
talk to Betty.[2] She's our release. She doesn't take it personally. She

lets us get it all out. If it's personal, we go to her office and talk. If it's a group complaint, we go to her, and if it's legitimate, she's take care of it. She'll pacify us if not." Unit A staff may talk so freely with their supervisor because she is both receptive and responsive to their concerns. For instance, one day the field worker overhead several techs telling Betty that the physician had not been listening to them at monthly meetings. "I'm not going to let him break you down like this. I'm going to talk to him, and it's going to stop!" Betty literally shouted in reply. The respect this supervisor elicits from her staff is grounded in their experience of her as a trusted and effective advocate.

Unit B. Many Unit B techs use work based social support to help alleviate job stress, but they seek support primarily from a single coworker and not from the wider group of psych techs as is the case on Unit A. Their residents' special needs for constant supervision to control their aggressive outbursts may be partially explain this pattern. While other units assign primary responsibility to small groups of six to ten residents to one psych tech, who is known as their group leader, all groups on unit B were cared for by two technicians. But, other factors also differentiate the characteristics of social support on units A and B. For instance, unlike Unit A, where techs hold a common definition of social support at work, Unit B techs have varying ideas about what work based social support entails. Some define it as receiving encouragement from those who can empathize with their problems. For others, it is the ability to laugh and joke without causing hurt feelings or resentment. For still others, it is being able to call on coworkers for help with problems at work.

Like Unit A techs, techs on Unit B feel they can rely on one another when help is urgently needed, especially during residents' violent episodes. Some also do one another small favors like buying lunch for someone who does not have time to leave the unit. But none express the view so common on Unit A that the unit functions as a team. Although informal communication occurs on this unit, it most often takes place between group partners who work with the same resident group.

Again in contrast with Unit A, where unit-wide problems are discussed as a group, when problems occur on Unit B most techs either share them only with their group partners or with their family and friends. To a greater extent than on the others, many on this unit have either immediate family members or close friends who also work at the hospital. They have an especially supportive situation where the listener has worked in the same institution with a similar resident population and therefore readily understands the frustrations that occur. The existence of social resources off the unit but within the hospital itself may well reduce Unit B techs' desires for a broader network on the unit itself.

On this unit, techs do not look to the unit supervisor for help with problems or to provide them with other types of social support on a routine basis because she is often absent from the unit. When they have matters to discuss with supervisory level personnel, they usually go to the shift charge instead. However, she prefers that staff work problems out among themselves and she will only intervene if they cannot reach a decision. In sum, psych techs on Unit B look primarily to their group partners for support at work and not to other coworkers or supervisors.

Unit C. Overall, Unit C techs provide one another limited social support only in work-related situations, although one clique of two women

and a man socializes and discusses personal matters as well. For instance, unlike the techs on Units A and B who are consistently able to count on coworkers for help during residents' violent episodes, those on Unit C cannot even be sure of this type of assistance. Said one, "If I have a blow-up with [a resident], I can't count on [them] to help me out...It gets spooky sometimes." This theme of being unable to count on the help of coworkers when it is most needed runs throughout conversations and interviews with techs on Unit C.

Personal matters are rarely discussed among Unit C techs with the exception of the clique who are in frequent contact. "I don't talk here," said one tech. "It's a Peyton Place. They give me no solutions...I don't talk about personal staff here at all." Another's comment was similar: "With the people here at work, I usually just talk about work and rarely about non-work subjects." "What wouldn't you talk about here?" asked the interviewer. "Well, for instance, I wouldn't talk about my car." This contrasts with Units A and B where informal conversation is the norm.

But, not even matters related directly to work are freely communicated by all Unit C techs. When asked what they do when something troublesome occurs at work, one tech said she speaks directly to the person involved; a second talks about the problem with the members of her "clique"; and a third tries "to talk to other staff on breaks to get opinions." Some, however, keep even work problems entirely to themselves. "I let it [the trouble] bug me," replied one. From these comments, it is clear that Unit C techs vary markedly when choosing even those with whom they discuss work matters, for no consistent pattern emerged.

A clear pattern regarding the role of Unit C's supervisor, however, is seen. This supervisor is consistently described as being "easy to talk to"

and having "good rapport with the staff." Work problems are brought to the supervisor either in the hope of resolution or to simply express one's feelings. One tech explained, "I ventilate things to Chris...When I talk to Chris, I don't expect anything. I just want to get my point across." Another commented, "I feel a lot better talking to Chris; I get it out...I don't feel as frustrated." However, unlike Unit A where the supervisor helped create a supportive work environment, partly based on open communication, and her willingness to confront the administration, the respect and confidence that Unit C's supervisor engenders is not generalized into unit-wide social support among the techs themselves.

Unit D. From the perspective of Unit D techs, social support is totally absent from their unit. "It's the opposite here," said one. "People backbite each other too much. You can't say anything to anyone without it getting to the wrong person at the wrong time." Informal conversation here is largely restricted to topics directly related to the residents themselves or unit administrative affairs, and compared with the other units, there is strikingly little of even that type of verbal exchange. Instead, techs avoid social interaction by staying in their group rooms and keeping busy with paperwork and other tasks when they are in the psych tech station.

No techs in this unit consider themselves to be friends. None socialize off the unit, and four of the five interviewed said they keep problems and stress at work from intruding into their home life by "leaving the job and coworkers behind" when they leave work. They apparently do not use social resources off the job to help deal with stresses at work.

Some Unit D techs see the lack of social cohesion there as due to the role the supervisor takes in unit affairs. "She would never do anything like that," said one, referring to informal socializing or other unstructured interaction. This unit's supervisor has a different leadership style than some of the other Program HF supervisors and this style may influence staff's attitudes toward one another. The supervisor agrees with this assessment. "When I was a tech, my coworkers helped me out when I was going through my mother's terminal illness. I really owe that to them. But now with my changed role, I must keep my distance." Observations indicated that this supervisor seemed more involved with residents than with staff. Whenever questioned by the field worker about staff on the unit, the supervisor would change the subject to the residents and their behavior. Unlike techs on the other units, each of the Unit D staff members interviewed criticized the supervisor's performance. They said the supervisor "plays favorites," "is too bossy," "vetoes too much by not bringing them to team meetings," "is unorganized," "may be prejudiced," and "acts paranoid, childish, and unprofessional." When there are problems on this unit, techs go to the shift charge who talks to the supervisor for them. It may be that the staff on this unit are less supportive of one another in part because their supervisor does not set a positive example.

CMI RESULTS

Twenty-six psychiatric technicians in Program HF completed the Cornell Medical Index (CMI). Means, medians and ranges for each unit were calculated for the sections on Bodily Symptoms (e.g., blood pressure, allergies) and Behavior, Mood, and Feeling (e.g., depression, sensitivity, anxiety). The Mann-Whitney U test shows the difference in scores between

Unit A and the other three units to be significant at the .05 level (z = - 1.82). These results are presented in Figure 1.

(Figure 1 goes here)

CMI scores on Units B, C and D are quite similar to one another with median values of 28, 27, and 20 respectively. They contrast sharply with Unit A's scores which show a median value of only 10. These findings are noteworthy for at least three reasons: First, the lowest CMI scores are found on Unit A, which alone among the four is characterized by unit-wide social cohesion, the perception among techs is that they operate as a team, and the feeling that they can rely on one another in times of need. Second, despite demonstrable differences in the social environments of Units B, C and D, techs' CMI scores on those units cluster rather closely. Third, although techs on Unit D indicate that that they are unable to obtain **any** social support from their peers, their CMI scores are in fact somewhat lower than those on the units where techs feel they can elicit at least limited co-worker support. Hence, the demonstrated relationship between social support and health is not a straightforward one.

DISCUSSION

These pilot data show that many of the most troublesome job stresses Program HF's psychiatric technicians report are generated by the institutional environment in which the psych techs work. Psych techs are the main link between the institution and the severely and profoundly retarded population it serves. As such, they feel stressed when they try without effect to act on the residents' behalf (cf. Bogdan and Taylor 1975). They feel they know the residents better than do the other staff. Yet, by virtue of their positions, they are denied any meaningful role in the development of policies that directly affect residents, such as those

concerning behavior programming or the administration of medications. Furthermore, techs are expected to implement hospital policies which they believe were created not primarily to meet residents' needs but rather those of the institution. This leads techs to feel further frustrated when they see they are powerless to act on what they regard as the residents' best interests.

The conflicts psych techs perceive between their own needs and those of the institution form a second set of job stress-related issues. For example, techs resent the fact that decisions concerning unit schedules are made without considering the needs of the techs who must fill them. Similarly, they resent the incessant demands of paperwork which they feel interfere with their ability to provide good resident care. Most techs chose their occupations because they want to help others; they feel stressed when their ability to do so is blocked by what they see as mundane clerical chores. The extent to which the presence of social supports at work directly alleviates any of these job stresses is not clear from the data presented here. It may be that on the cohesive unit, there is also more effective communication between unit staff and administration which facilitates techs' ability to implement their own professional goals. Further exploration of this hypothesis is required.

Other job stresses psych techs report are inextricably linked to the social environment in which they work. While most jobs in America are performed without coworkers assistance, the job of the psychiatric technician cannot be done alone. Psych techs need help when they subdue residents during violent episodes or when they themselves are attacked. Although the unpredictability of these episodes makes them stressful for

all techs, they are greater for techs who work on units where they cannot be sure that their coworkers will come to their aid. In many other ways as well, techs rely on one another for help on a regular basis: from getting residents up, dressed, groomed, and fed in time for their morning departures from the unit; to cleaning up after those who smear feces on themselves, other residents, or the unit; to the lifting and transporting of nonambulatory residents. For psych techs, then, work based social support in part involves the giving and receiving of help. Our data indicate that the extent to which techs can count on such help influences their attitudes about their jobs, and may also affect their health. Thus, for psych techs, the effects of job stress and social support must be analyzed together, for they are intertwined.

On all four units, work based social support is minimally defined as providing coworkers with help when it is sought. But on Unit A, the cohesive unit, it also means teamwork in a broader sense, and the resolution of unit-wide problems by the psych techs as a group. Techs who work on the cohesive unit are also in better health. Our pilot data do not allow us to determine all of the reasons why these associations occur. Unit A's supervisor's strongly supportive attitude toward her staff and her willingness to act as an advocate on their behalf undoubtedly play an important role in creating a socially cohesive unit. Also, the fact that the psych tech group is a relatively stable one contributes to the development of dependable ties at work. Yet, these findings raise still other questions for further research. These include: Under what circumstances will supportive work networks fail to evolve despite a supportive supervisor, as was the case on Unit C? Can supportive work networks evolve in the absence of a supportive supervisor? What is the

role of the unit supervisor in influencing patterns of unit-wide social interaction during the afternoon and night shifts when unit supervisors are ordinarily not present? Does the shift supervisor assume a more prominent role? Does a nonsupervisory individual become a fulcrum for unit-wide social interaction instead? Are group ties inherently less intense on shifts where a unit supervisor is absent? Can supportive work networks evolve within unstable work groups? This last issue is especially pertinent for the field of nursing and allied health care where significant staff turnover is often the norm.

Differences in the CMI scores indicate an association between social cohesion and better staff health. On Unit A, the cohesive unit, the median scores are at most half of what they were on the other three units. Hence, the healthiest psychiatric technicians who participated in this study work on the most socially cohesive unit. However, too few data were collected to determine whether individuals who work on less cohesive units, such as Units B and C, but who have strong ties to other coworkers on or off their units, are also in better health. Thus, the relative importance of a supportive social environment as opposed to a supportive social network needs to be more fully explored.

In this pilot study, the issue of blocked mobility does not appear to influence psych techs' perceptions of work stress in any significant way. Dissatisfaction with the amount of paperwork that the techs are expected to complete, and frustration with their inability to influence policies regarding treatment decisions and scheduling, might at first glance appear to stem from techs' low position on the status hierarchy within the institution. Yet, from techs' own perspectives, blocked mobility per se is

not an important concern. The vast majority of those interviewed are satisfied with their current positions for one of three reasons: they are doing work they essentially enjoy; they sought state employment for the educational and promotional opportunities such employment provides; or they regard their current jobs as a means by which they can attain longer range professional goals. It is perhaps for this reason that techs' inability to control fundamental aspects of the work environment instead emerges as the issue that unites the sources of job stress techs report. Repeatedly, techs indicate that they feel stressed and frustrated when they cannot do their work as they feel it should be done. It is not, therefore, the tasks themselves that techs find stress-inducing but rather the way these tasks are structured, defined, and controlled by the institution. This fact may help explain why techs on the cohesive unit also had the best health: The social environment these techs create is one domain that they can, and do, control.

Whether issues of control are as important a source of job stress for ancillary nursing staff in other treatment programs or other types of institutions, or for RNs, requires further investigation. Also needed is further research on the nature of the relationship between job stress and poor health in nursing staff, and the extent to which social supports at work can reduce the negative impact of job stress on nursing staffs' health. These pilot data have been presented in the interest of stimulating needed discussion on these important issues.

NOTES

[1] Copies of the interview schedules may be obtained upon request from the author.

[2] Pseudonyms have been used throughout.

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FIGURE CAPTION

Figure 1. Cornell Medical Index (CMI) scores for individuals on four

units. The median value within each unit is indicated by

an open circle. Solid lines join the scores within a unit,

with the extreme upper and lower observations joined to the
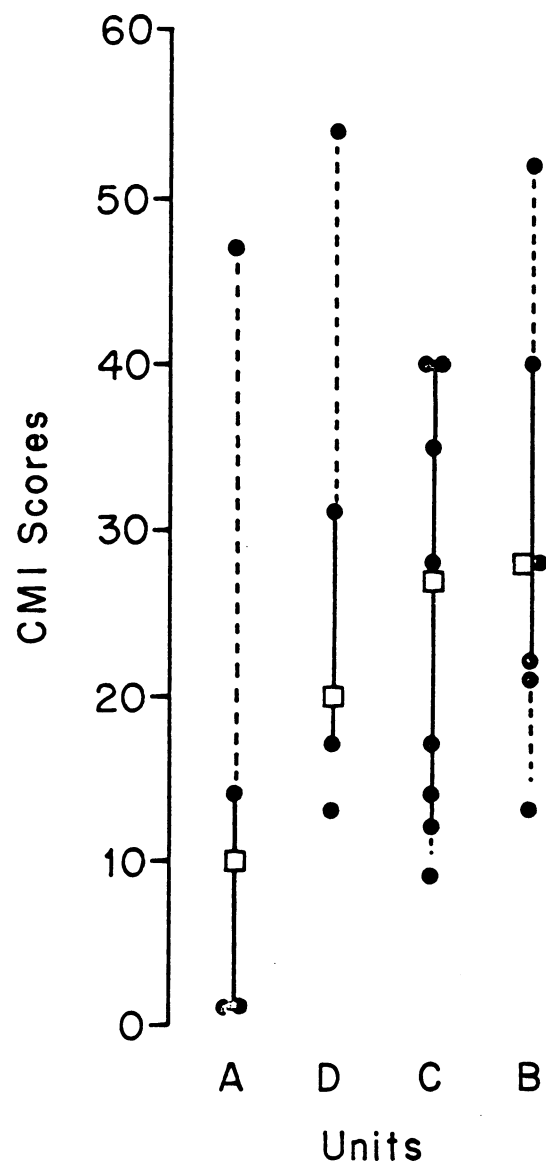
others by dotted lines.

Figure 1