

stress



**Measuring stress and burnout amongst
homelessness workers in Northern Ireland**



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Stress: everybody knows what stress is, no one knows what it is. There is no agreed definition.

Despite no standard definition, it is nonetheless generally acknowledged that stress is:

the product of an imbalance between appraisals of (job) demands and resources available to the individual.

What does this mean?

There is a difference between stress and pressure. We all experience pressure on a daily basis, and need it to motivate us and enable us to perform at our best. It's when we experience too much pressure (too many demands) without the opportunity to recover (or the resources to cope) that we start to experience stress.



Demands are stressors - and require **effort** to deal with. Demands can be physical, psychological, social (e.g. difficult co-workers or superiors; family), or organisational.

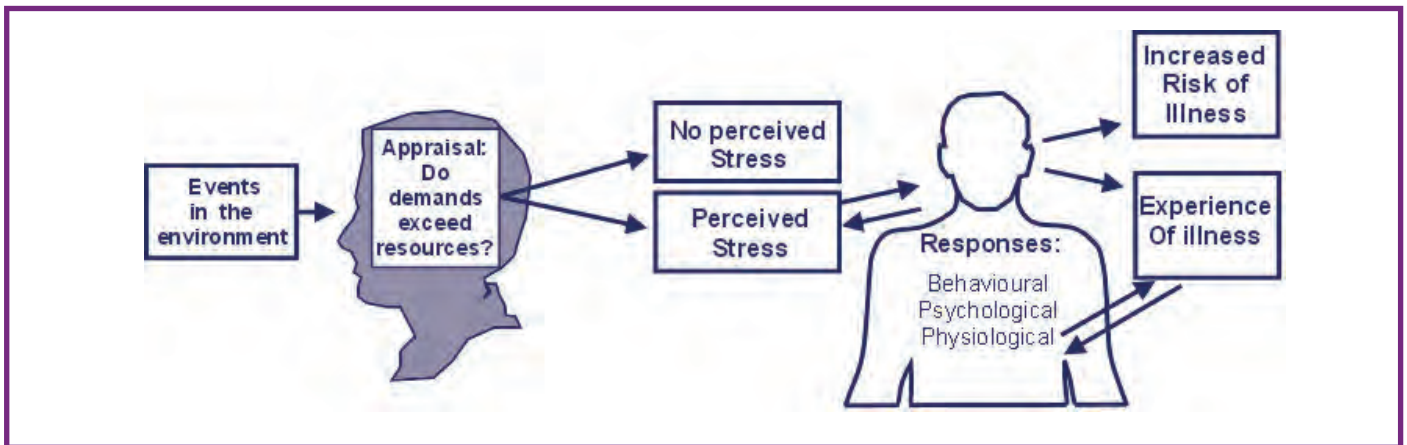
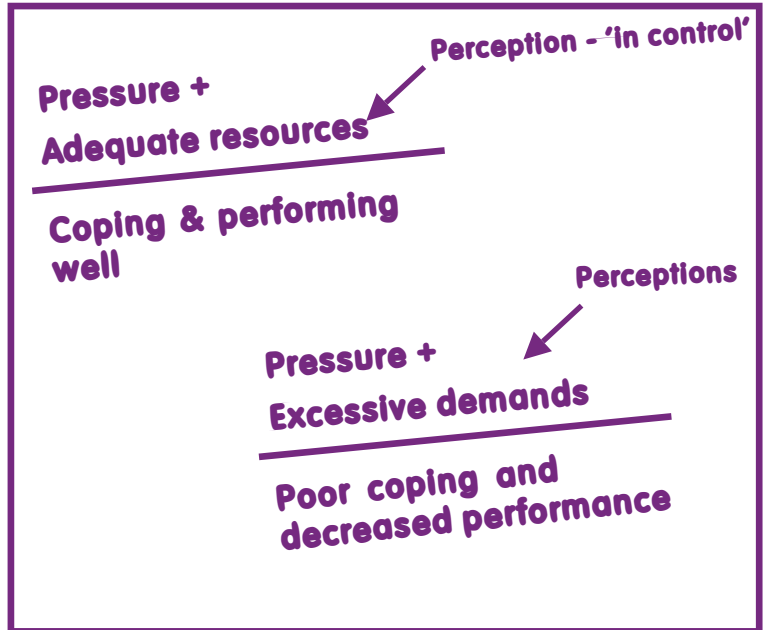
Resources are those elements that help reduce the effects of demands. The following definitions focus on job demands / resources, but the same can be applied to other areas of a person's life.

Demands and resources are defined as:

(Job) demands refer to those physical, psychological, social, or organisational aspects (of the job) that require sustained physical / psychological effort. Due to this sustained effort, there are certain associated physiological / psychological costs¹

(Job) resources refer to those aspects (of the job) that may reduce demands and associated costs. For example, good social support, well defined job roles, etc.²

Responses to demands and the individual's ability to cope with external pressures is dependent upon a cognitive appraisal of the stressor and the coping strategies available to them.³ Stress, therefore, is perceived in relation to the person's previous experience, success or failures in dealing with similar situations, and familiarity with the situation⁴. Each stressor is different and each individual has different different perceptions of the demands and of the importance of meeting those demands and different levels of perceived ability to cope with these.⁵



Lazarus and Folkman (1984) proposed a model that takes all these factors into account. In this model, they define the stress process as:

*"A particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being"*⁶.

Based on this definition, **occupational stress** can be defined as:

*"the interaction of work-specific conditions and individual characteristics where (negative) physical / psychological consequences occur in response to a stressor, when the requirements of the job do not match the perceived capabilities, resources or needs of the worker"*⁷.

Stress is a very real issue in social care / health services

Prior to this study, the effects of stress on those working with homeless people in Northern Ireland were overlooked at an empirical and bibliographical level. The focus of UK and European studies has been on healthcare professionals in other fields, typically, nursing, community mental health, and social work¹⁶⁻²¹.

In general, findings indicated that those working in social care and health workers experienced considerable stress, which affected productivity, job satisfaction, and ultimately the worker's health²²⁻²³. Lack of resources; poor interpersonal relationships with other staff; a mismatch between the skills learned in training and those required by the current work environment; and home/work conflict have all been identified as major sources of stress²⁴. A number of demands related to the intense nature of worker-client interactions, and regular confrontation of complex, difficult and potentially violent behaviours²⁵⁻²⁶. In general, irrespective of specialty, working with clients who had behavioural problems is related to feelings of anxiety, depression and burnout.²⁷

Within mental health nursing, community work has been found to be particularly stressful.²⁸⁻⁹ Working in the community was found to be more stressful than working in hospital settings³⁰. 'Frontline' workers often face excessive stress due to the nature of their jobs³¹ and were more at risk than their non-frontline colleagues³².

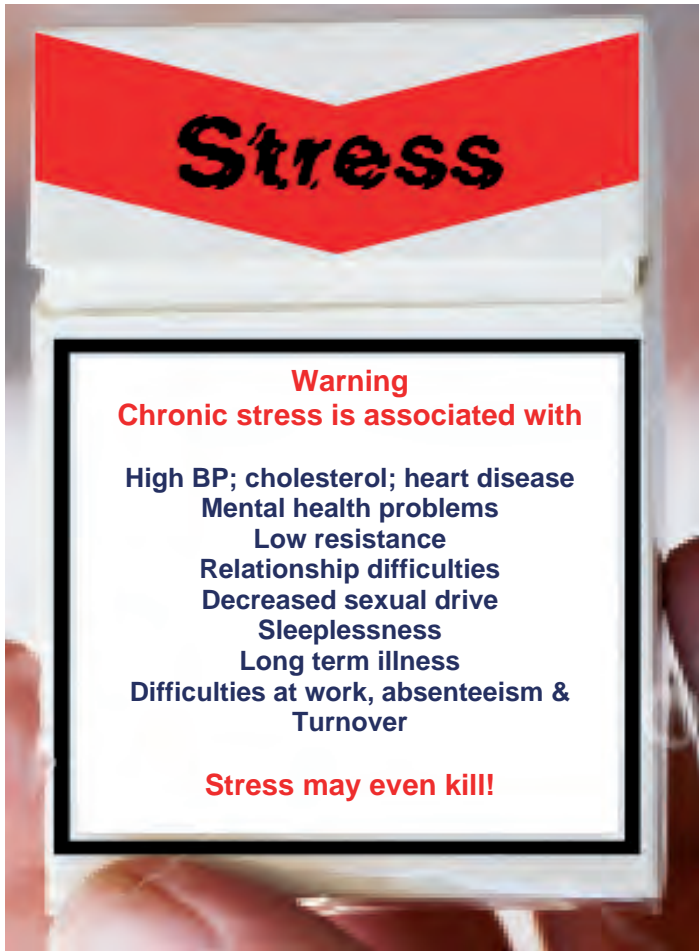
In other studies, important stressors for community-based workers were limited resources, workload and increased bureaucracy, and organisational climate³³.

Other possible sources of stress included workload, client attitudes and behaviour, poor relationships with colleagues, superiors, and organisational climate³⁴

Stress is a very real issue in NI

- 70,000 people suffer from ill health caused or made worse by work (01/02)
- Stress is the largest contributor to overall estimated days lost from work-related ill-health: 28.5 days / year / person
- 14.4 million working days were lost to stress, depression and anxiety in 2005
- Stress accounts for over 1/3 of new incidences of ill-health
- £4 billion a year lost due to work-related stress (2001)



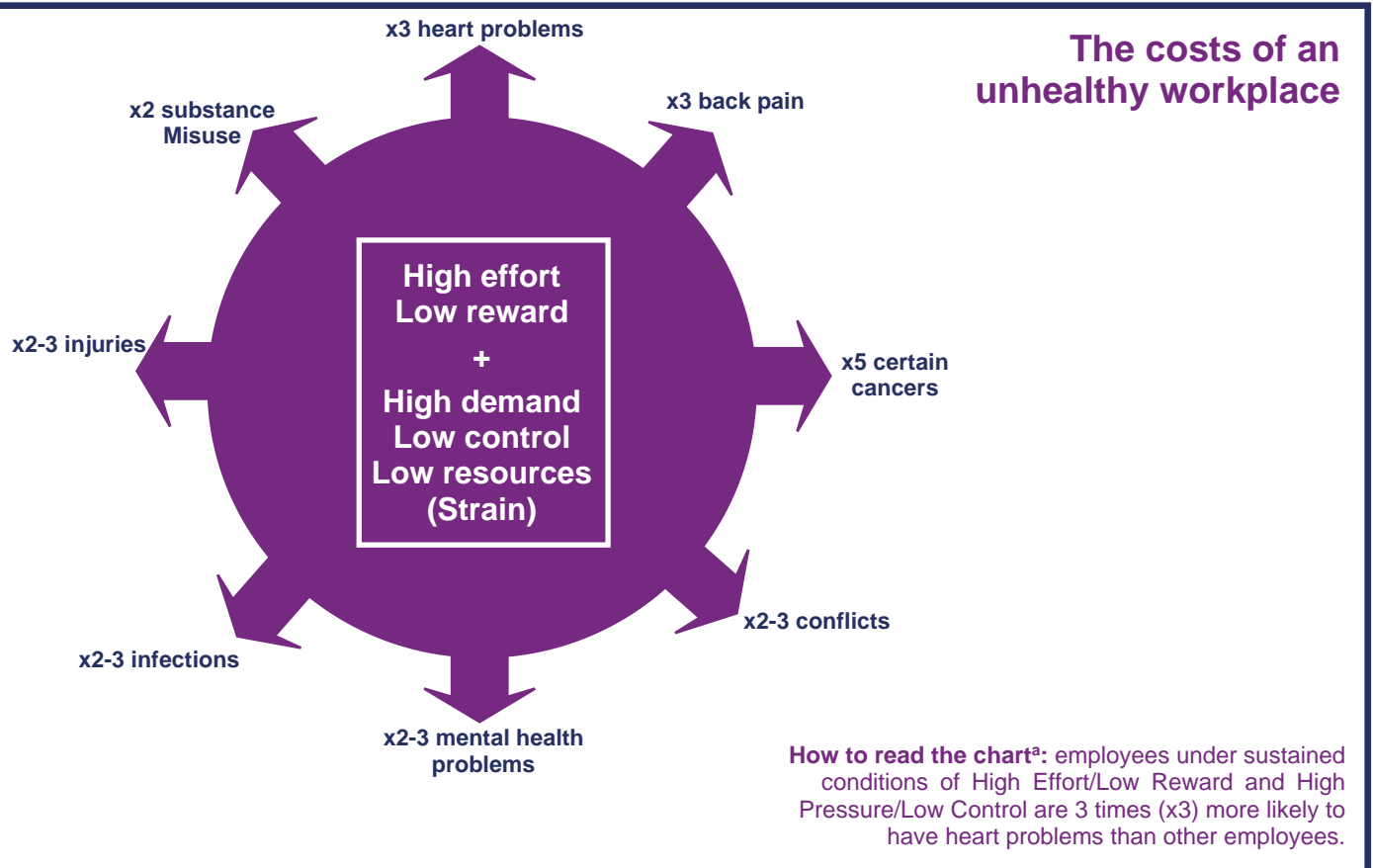


In the short-term, adaptive responses may be elicited. Where negative effects are experienced, these are transitory. Acute responses to stress may manifest emotionally, behaviourally, cognitively, or physiologically.⁸

Where demands outweigh or put excessive weight on resources and the ability to cope, the consequences are likely to be considered excessive or threatening to the individual. This impacts upon their health and effectiveness in the workplace and home. Continued chronic stress results in maladaptive changes, deleterious effects on physiological systems and impaired cognition. These often lead to mental and physical ill health.⁸

Signs and symptoms include:		
Physical	Psychological	Behavioural
Sleep pattern changes	Feeling overwhelmed / helpless	Noise sensitivity
Rapid weight change	Irritability / Feeling tense	Poor sleeping habits
Fatigue	Intolerance of others	Anxious / avoidance behaviours,
Vague aches and pains	Aggressiveness	Excessive / risky use of 'props' (e.g.
Menstrual cycle changes	Restlessness	Drugs, food, etc.)
High blood pressure	Anxiety & panic attacks	Over eating or Obsessive dieting
Excessive sweating	Concentration and memory problems	Loss of personal appearance
Breathing difficulties	Tearfulness	Work related difficulties
Impotence	Increased worrying / Worry about the future	Loss of interest in sex
Digestion changes	Cynicism and lack of interest	Accident-prone and unsafe behaviour
Loss of sexual drive	Loss of confidence	Develop nervous mannerisms /
Headaches	Loss of sense of humour	repetitive behaviours
Impaired immune system	Difficulty in making decisions	Emotional outbursts / over-reactions
Recurrence of illnesses	Confusion and disorientation	Interpersonal relationship problems
Indigestion	No enthusiasm	Withdrawal from relationships
Palpitations	Self esteem problems	
Skin problems	Self-criticism	
Pains - chest, muscular	Feelings of guilt	
Fainting	Mental health problems, e.g. depression,	
Frequent colds, flu	psychiatric disorder.	

The costs of an unhealthy workplace



Burnout

Studies have shown that long-term exposure to job-related stressors can result in extreme strain reactions, such as burnout.^{9,10,11,12,13,14} Burnout and stress are often found close together in the literature, the one (burnout) being presumed to flow from an extreme experience of the other.

Burnout is a common 'occupational disease' amongst health care professionals¹⁵, and can impair the quality of care delivered to clients as well as having serious consequences for the personal life of the individual worker. Over the years, there has been much debate as to what constitutes burnout and how it might be best measured. Despite a lack of standard definition of burnout, it is generally seen as a prolonged response to chronic job-related stressors⁵⁸ that results from incongruence between demands and resources. For the purposes of this study, burnout was defined as follows:

The degree of physical and psychological fatigue experienced by the person, which they perceive to be due to (a) work in general (b) working with clients and (c) personal factors



As a process, it is not necessarily exclusive to work. Essentially, burnout is likely to occur in situations that have been emotionally difficult for an extended time⁵⁹ and it is the experience of fatigue across both work and non-work contexts⁶⁰.

A great deal of research has been devoted to the understanding of factors contributing to burnout and its consequences³⁸. Since the 1980s, more than 5,500 studies on burnout have been published³⁹. Generally, research indicated that work-related factors such as high demands, low resources (e.g. low influence / low social support), and imbalances in perceived control and role clarity, predict burnout⁴⁰. Stress and burnout, in turn, have been demonstrated to be significant factors in the development of both physical and psychological illness⁴¹, and to be associated with absenteeism, sick leave, disability claims, and high job turnover⁴².

Burnout

- ❑ In a number of European population-based studies³⁵, 5–16% of the workforce reported severe burnout. These data are probably indicative of the situation in most other developed western countries³⁶.
- ❑ For example, survey research indicated that up to 5 million people in the UK feel 'very' or 'extremely' stressed by their work, with approximately 10% experiencing this type of stress at a level that they believe is making them ill³⁷.
- ❑ Furthermore, this survey indicates that work related stress costs British society about £3.7 billion every year (at 1995/6 prices)

Burnout is often higher in health / care service professionals (nursing, social workers, and residential care staff) and a major factor in absenteeism, high job turnover, and other indices of job stress⁴³⁻⁴⁸. For example, two studies of burnout⁵⁰ among UK oncologists reported prevalence to be 28%. In another⁵¹ 45% of UK psychiatric nurses rated themselves in the top third for burnout; and Jenkins & Elliott (2004) reported that 51% of psychiatric nursing staff sampled experienced burnout. Leiter & Harvie (1996) found that mental health problems such as burnout and stress frequently manifest as physical conditions and, as a result, healthcare workers tended to report higher rates of physical disability than other occupational groups⁵². Further, research findings showed that burnout was associated with several measures of depression, anxiety, and somatisation (that is, to feel painful physical symptoms with no known causes)^{53,54}. Also, these mental health problems were correlated with subjective feelings of being overworked, understaffed, poorly managed and with job insecurity, and organisational change⁵⁵⁻⁵⁷. This demonstrated that the final appearance of burnout depended on how one perceived and responded to stressful situations.

Summary of research process

Background to study

This study represented the first attempt to empirically explore differences in the stressor and burnout profiles amongst a representative sample of paid employees in the homelessness sector in NI. Prior to this study, there was no empirical focus on the effects of stress and burnout upon workers working in the homelessness sector in UK, Ireland and across Europe.

Just as there was a paucity of data regarding burnout amongst this sample prior to the current study, so data regarding the level of exposure to aggressive incidents in the homelessness sector in NI remained undocumented. This study aimed to assess the frequency and type of aggressive behaviours at work, as experienced by managers and non-managers working for homelessness organisations, as well as its relationship with burnout.

Design & sample details

This study was a questionnaire-based survey, employing group administration as the primary method of data collection, supplemented with postal administration, and used a sample of managers and non-managers employed in hostel and non-hostel settings within the homelessness sector in Northern Ireland. In total, 200 issued questionnaires were postal, 180 were group administered. Of all questionnaires returned that could be used, 35% were postal questionnaires, the remainder group questionnaires.

Participants

380 staff were issued questionnaires, 266 questionnaires were returned, yielding a response rate of 70%. From these, a final data set of 244 was achieved when all eligible questionnaires were collated. Table 1 describes returned questionnaires by job type, job location, and sex of respondent.

Table 1: *Descriptive analyses of eligible questionnaires*

	Job type		Job location		Sex of respondent	
	Manager	Non-manager	Hostel	Non-hostel	Male	Female
Number	60	184	177	67	70	174
%	24.6	75.4	72.5	27.5	28.7	71.3

Burnout was measured using the **Copenhagen Burnout Inventory**. The questionnaire measures burnout on three scales. These are:

- (a) **Personal burnout:** refers to general fatigue in the person's life: 'How exhausted are you?'
- (b) **Work burnout:** refers to fatigue relating to work in general, and applies to everyone in the workforce;
- (c) **Client Burnout:** refers to the fatigue that the person attributes to working with clients, in this case people who are currently homeless and using homelessness services.

Psychosocial work environment factors and their role in worker well-being were assessed using 15 scales from **Copenhagen Psychosocial Questionnaire**, and four self-design scales. These focus on:

- workloads / work demands,
- job role clarity and conflict,
- social support,
- predictability at work,
- mental health, stress symptoms, and vitality amongst others.

Both the CBI and COPSQ were developed and tested in the PUMA study (Project on Burnout, Motivation and Job Satisfaction), an ongoing prospective study amongst 1914 human services employees in Denmark. This study provides the normative data against which results from the current study will be compared.

The current study also explored the role of colleague and client aggression as stressors amongst the sample.

Scoring the CBI and COPSQ

Scores were calculated by taking the average of the items within each scale. All items have five response categories and scoring: scores could theoretically range from 0 to 100, with high scores indicating high levels on each scale. For certain analyses, scores were further dichotomised by the midpoint of each scale to define low (<50 points) and high (50+ points).

By choosing the midpoint of the scale, it was hoped to ensure that the definition of low and high burnout was independent from the actual distribution of burnout in the study sample. Furthermore, by comparing each burnout scale, it should be possible to identify persons who are tired but who attribute the fatigue to personal or client as opposed to general work factors

Burnout scores for the sample are given in the following table:

Average burnout scores for the whole sample were		
Personal	Work-related	Client-related
44.0	43.0	45.4

Participants can score between 0-100 on each scale

These scores were greater by 8-12 points than those reported in a number of studies using these questionnaires. As a general rule of thumb, differences of 5+ points are considerable; 15-20 points are substantial, per se and for the employee.

On this basis, employees in homelessness organisations across Northern Ireland **reported near substantial levels of burnout and are very likely at risk of related outcomes.** These include, but are not limited to:

- Diminished quality of working and personal lives (Lambert et al, 2004),
- Increased psychiatric and physical morbidity (McGrath, 2003; Metcalfe et al, 2003),
- Increased rates of occupational injury and mortality (Kristensen et al 2005).

There are also potential negative outcomes for organisations, including:

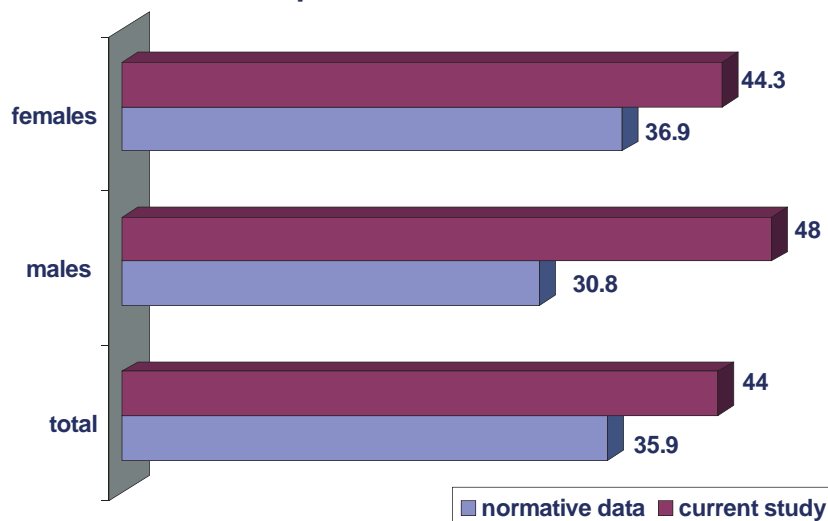
- Worker dissatisfaction
- Turnover
- Early retirement
- Lowered productivity and
- Increased likelihood of grievance procedures. (see full report).

□ These scores are also greater than those reported in normative* data as calculated in PUMA study, for which instruments were designed and tested. See graphs overleaf.

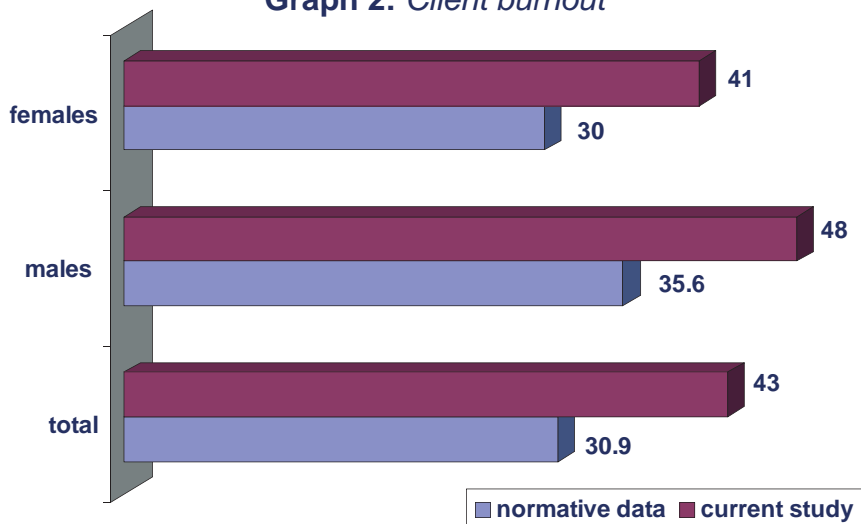
* comparative data that describes established patterns across a number of groups and communities.

Comparing burnout average scores: the current sample versus normative data

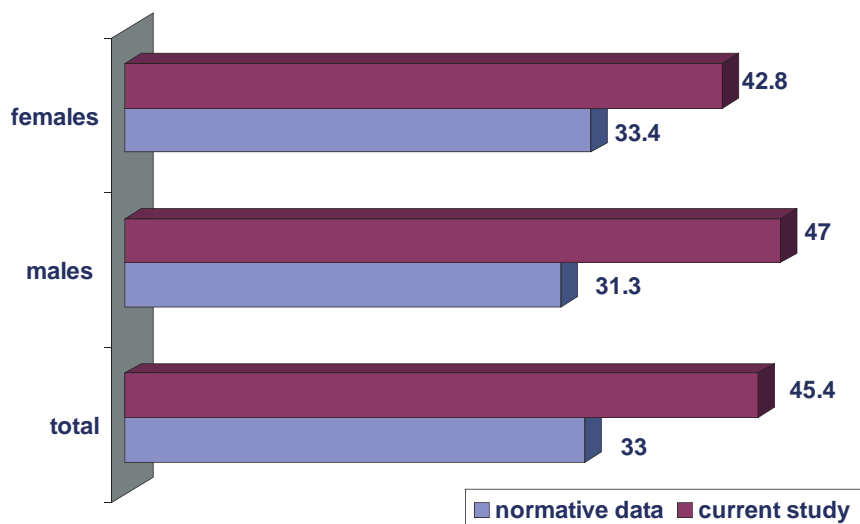
Graph 1: *Personal burnout*



Graph 2: *Client burnout*



Graph 3: *Work burnout*



Proportions of the sample who were classified as 'high burn out'

Burnout amongst Northern Ireland's homelessness workers has reached extreme levels. Almost half of all participants were classified as experiencing 'high' burnout (i.e. a mean score of 50+ points, on a scale of 0-100) on all scales (and at risk of the outcomes already described).

These proportions were more than double that reported by PUMA (normative data):

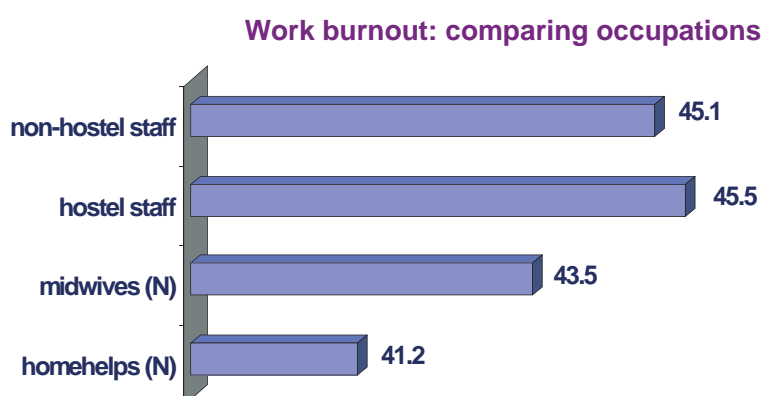
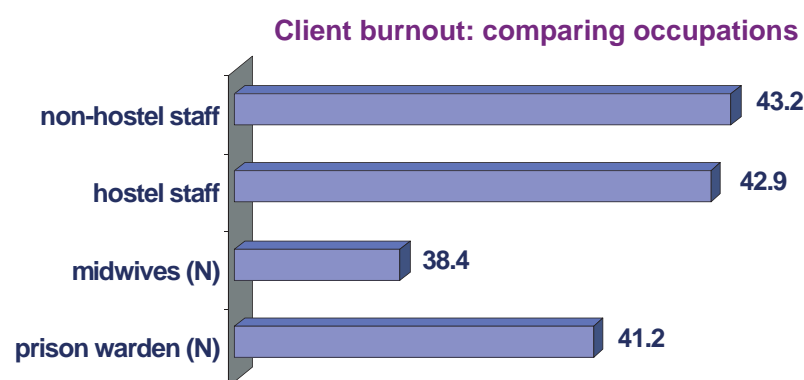
personal		Client-related		Work-related	
Current study	PUMA	Current study	PUMA	Current study	PUMA
47.5	22.2	42.6	15.9	48	19.8

Proportions in the current sample were also greater than those reported in several European (including UK) population-based studies⁶¹⁻⁶⁴, where 5-16% of the workforce reported severe burnout^b. Overall, based on available comparisons, the proportion of workers high in burnout in the homelessness sector in Northern Ireland was at least two to three times that typically reported amongst human service workers across Europe, and should cause some concern.

Comparing Homelessness workers in NI to other professions

Furthermore, mean scores from the current sample were higher than those noted for the top ranked (i.e. most fatigued) occupations in PUMA. These data in combination indicated that burnout was not only experienced by many if not most of the workers in the sample, but that it was (and is) a very real and serious issue for all workers and their employers in homelessness services. Whilst previous studies reported lower levels of burnout, the levels reported were nonetheless associated with a number of indicators of ill-health, as well as negative organisational effects⁶⁵.

On that basis, it can be conjectured that the levels of burnout amongst homelessness workers in the current sample increase the likelihood of at least comparable, if not greater, burnout-related outcomes.



Key to both graphs: (N) = top two ranked occupations from PUMA normative data. (non-)hostel staff refer to CHNI study

What do these results mean?

In summary, burnout amongst Northern Ireland's homelessness workers has reached extreme levels. These proportions are at least two to three times that typically reported amongst human service workers across Europe, and should cause some concern. Burnout is a very real and serious issue for all workers and their employers in homelessness services. Previous studies reported lower levels of burnout, but were nonetheless associated with a number of indicators of ill-health, as well as negative organisational effects.

Differences between males and females

Data suggested that males in the sample were more likely to have burnout scores across the three burnout scales than females.

Differences between managers and non-managers

Managers were more likely to be 'burnt out' and to have attributed this burnout to general work conditions, client factors and aspects of their personal life than non-managers.

With regards to work burnout, perhaps the demands posed by managing an increasingly diverse mix of clients, dealing with increasing accountability and administrative demands, as well as limited resources were appraised as outweighing resources available. This in turn, may have intensified the feeling of strain experienced by managers and contributed to a feeling of being over-stretched,

With regards to client burnout, actually being overstretched may have contributed to increased manager-client contact. This contact was compounded by the level of 'emotion work' managers engaged in: 78.4% of managers reported hiding emotions from the clients they have contact with either 'almost all the time' or 'more than 50% of the time', compared to 69.4% of non-managers, whose primary duties were defined by client-work. Although managers were more likely to show higher mean burnout scores than non-managers across scales, the difference reported on client burnout was not statistically significant. It should be noted that work boundaries within the sector between manager and non-manager are not clear-cut: managers will have significant contact with clients. For example, 73.4% of managers claimed to have contact with clients either 'almost all the time' or 'more than 50% of the time', compared to 93.5% of non-managers, whose duties were defined by such contact. Thus, client contact for each job-type was likely to be in many cases comparable (both in actual frequency and perceived intensity), making it difficult to detect differences in client-related burnout.

With regards to personal burnout, By comparing the scale for personal burnout with that for work-related burnout, Kristensen et al (2005) indicated that persons who are tired but who attribute the fatigue to non-work factors (e.g. health problems or family demands) could be identified. In this regard, managers may simply have perceived themselves as more fatigued than their non-managerial counterparts. Perhaps some unknown crossover or interaction of factors between client, work or personal life was operating. This study was exploratory and could not factor these potential relationships into its design, but these data now offer scope for future research opportunities.

The relationship between burnout, demands, and resources

Data indicated that as demands (from clients, from colleagues, external partners and / or workload; and the demands of hiding emotions from clients) increased, so did burnout. Conversely, high scores on resources were associated with low burnout scores on all three measures: so, staff who felt that they had high levels of social support, clear work roles, high a degree of predictability at work, and who felt their work had meaning, and some degree of influence in decision making, were less likely to be experiencing extreme levels of burnout. (Note, it doesn't mean that they were **not** 'burnt out'). This study also suggests that higher levels of burnout are associated with more frequent episodes of somatic (illness, palpitations, etc.), cognitive (inability to concentrate, irritability, etc.) and behavioural (withdrawn, aggressive, etc.) stress. This study provided strong support for the role of behavioural stress, emotional demands, and need to hide emotions from clients in the experience of burnout. Furthermore, low meaning of work, low role-clarity and cognitive stress predicted burnout, as demonstrated in previous research⁶⁶⁻⁶⁹, but to lesser degree. The most striking result was that two of the main factors in contemporary occupational psychology, influence at work (control) and social support did not significantly predict burnout in this study. These findings contrasted with those from other studies that have reported associations between influence at work and social support with burnout across several occupational groups⁷³⁻⁷⁵.

Aggressive behaviours

As aggressive increased (whether client or colleague perpetrated), so did the likelihood of experiencing burnout. The data confirmed that colleague and client aggression exist within the homelessness sector, though colleague aggression seemed to be infrequent. 34% of the sample reported experiencing 'high' levels of client aggression, compared to 9.8% reporting similar levels of colleague aggression. Levels of client aggression experienced in the current sample were comparable at the lower end to those experienced by nursing staff across the UK. In terms of colleague aggression, levels were considerably lower than reported in UK studies & comparable to several European studies⁷⁰⁻⁷² (see full report).

Emotion management

Emotion management is a prominent feature of organisational life in the human services, and the concept of 'emotional labour', defined as "the effort, planning and control needed to express organisationally desired emotion during interpersonal transaction"⁷⁶, is thought to have negative outcomes for the worker. Frequently or constantly maintaining organisationally mandated emotions leads to strain, including burnout⁷⁷. Findings in the current study demonstrated that high demand to hide emotions and be 'professional', when coupled with low meaning at work, and low role clarity were associated with client burnout. Similarly, high behavioural stress, general work demands, and low vitality (i.e. energy levels) were associated with work burnout.

Discussion and recommendations

Given the extreme levels of burnout amongst Northern Ireland's homelessness workers some consideration should be given to effective intervention and prevention packages that can be implemented across organisations. Most intervention programs are aimed at the individual, usually combining various methods such as relaxation techniques, cognitive stress management, time management, and social skills training⁷⁸⁻⁸⁰. Several reviews have been conducted of interventions designed to reduce occupational stress⁸¹⁻⁸². The general finding of these reviews is that such interventions are effective in reducing exhaustion, which is core to burnout⁸³⁻⁸⁵.

Stress can be managed effectively and inexpensively. It can be administered in-house; there is no stigma attached to stress management training; and it enables the worker and organisation to deal with concerns that stem not only from the job but from the home⁸⁶. On the other hand, there are limits to what can be expected from stress management. Stress management will not eradicate structural / organisational difficulties. Although stress management programmes might identify organisational stress factors, actual redesign or structural changes undertaken to eliminate or reduce these remain entrenched within the organisation, not within the remit of stress management programmes.⁸⁶

From the perspective of wishing to follow good practice, the various elements of a comprehensive stress prevention programme have previously been described in a Health & Safety Executive research report⁸⁷. Stress has been largely addressed from an individual perspective, yet a strategic initiative can only be achieved by understanding stress as part of the fabric of organisational life^{87,88}. Organisational interventions require the involvement of whole organisations.

Conclusions

Burnout amongst Northern Ireland's homelessness workers has reached extreme levels. It is an issue that requires competent management and the utilisation of effective stress management techniques.

This study represented the first attempt to empirically explore differences in the stressor and burnout profiles amongst a representative sample of paid employees in the homelessness sector in NI. Prior to this study, there was little, if any, empirical focus on the effects of stress and burnout upon workers working in the homelessness sector in UK and across Europe. Certainly, it represented the first empirical study examining these factors employing a sample of homelessness staff service providers across Northern Ireland. As such, it is unique, and was a timely exploration of the possible relationship between occupational stress and psychosocial factors, and how workers in this field differentially experience these. It provided further empirical data to burnout field, and contributed to the theoretical model forwarded by Kristensen and colleagues, by demonstrating the effectiveness of the CBI and COPSOQ within this population, their model, and the notions of burnout and its relationship to psychosocial factors.

Overall, the results provided some valuable insight into the prevalence, nature and experience of burnout across the sample. Analyses on determinants of burnout showed that high behavioural stress, high emotional demands and demands for hiding emotions predicted burnout on all domains. It is concluded that many of the work-related variables associated with high levels of psychological ill health are potentially amenable to change. Burnout may be preventable and the pattern of scores across the burnout scales can provide a focus for subsequent stress-management programmes by highlighting the most prominent sources of stress. The reduction of workload stress and the increase of resources, e.g. support mechanisms or stress management, should be a priority for action. While feelings of emotional exhaustion may, to a certain extent, be an inevitable consequence of working in the highly demanding environment in which homelessness workers practice, appropriate interventions and prevention schemes are necessary to avoid and reduce the consequences of burnout.

