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WORK AND WOMEN'S HEALTH
THE ROLE OF JOB-BASED SOCIAL SUPPORT [1]
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ABOUT THE AUTHOR.

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As women enter the workforce in ever growing numbers, we should expect that such employment will affect their health. Yet we know very little about how work environments impact on the health of working women. Studies of stress in women who work usually consider paid employment per se to be the problem, or the difficulties involved in simultaneously fulfilling work and family roles (Haw 1982). These studies overlook the possibility that stresses generated by specific features of a work setting might also contribute to the problem. Perceived work stress has also seldom been studied in female workers, although there have been several studies of the phenomenon in men (Cassel 1970; House 1981; Kasl 1978). But rarely have researchers sought to measure or examine the work conditions women themselves consider stressful, or the effects of these perceived job stresses on women's health.

These gaps have particularly serious implications for the field of nursing, which is made up largely of women. Although many consider job stress the number one reason nurses seek other positions--or other professions, there have been surprisingly few empirical studies on the subject (Greenberg and Valletutti 1980). Rarely have nurses been asked to describe in their own words the work conditions they experience as stressful, how stressful work condi-

tions make them feel, and what, for them, are the most effective means of dealing with stress at work (Marshall 1980:25; Steffen 1980). Also lacking are data-based studies on the relationship between perceived work stress and actual conditions, and on the impact of job stress on nurses' health (Gentry and Parkes 1982). Research that looks at stress in male nursing staff, or compares female with male nurses, also appears to be nonexistent. Furthermore, research on stress in nurses has focused overwhelmingly on RNs, particularly intensive care unit nurses, who are an elite but very small segment of the larger population. Licensed vocational nurses, nurses aides, and other types of nursing attendants have been totally ignored (Numerof and Abrams 1984). Similarly, I was unable to find any studies of job stress in nursing staff who care for chronically ill, institutionalized, disabled, or nursing home populations.

In several studies of male workers, reports of stress and poorer health have been associated with feelings of powerlessness on the job or the lack of control over one's work (Frankenhaeuser 1981; Gardell 1982; Hamburg et al. 1982; Kahn et al. 1981; Stellman 1977). An important but often overlooked dimension of worker control involves the availability of work-based social resources which could provide a means through which workers exercise autonomy from supervisory control. Moreover, while research has shown that workers find it helpful to have peers with whom they can talk about work related problems, the role of work-based social support in promoting good health or preventing illness is not yet well understood (House 1981; Pines 1983). Yet studies demonstrate that many women regard social contact as an important benefit of employment; others show that for some, their work associates are their closest friends (Waldron 1980). Therefore investigating the circumstances under which job-based friendships can contribute to better health for women workers is a pressing concern.

I therefore designed an exploratory study to identify the sources of work stress for ancillary nursing staff who cared for severely and profoundly retarded residents of a state institution. I was especially interested in assessing the role of work-based social support in reducing the negative impact of job stress on the staff's health. Differences between female and male nursing staff with regard to their perceptions of job stress, their use of work-based social supports, and their health was another focus of the investigation.

The setting for this study was a California state institution for the severely and profoundly developmentally disabled. Nearly 60 percent of the hospital's 1100 resident patients were male; more than three fourths were adults over 18 years of age. The IQs of 99 percent of the residents were below 50, and a full 50 percent had IQs below nine. Consequently, they required total staff supervision at all times. Most had to be dressed, fed, and toileted several times a day. They were typically nonverbal; a great many were nonambulatory; some had multiple handicaps, multiple chronic medical conditions, or were prone to seizures or aggressive, self-abusive or self-mutilatory behaviors.

Resident patients were assigned to one of seven treatment programs based on their developmental and medical needs. Units were run by between 35 and 40 nursing staff, usually psychiatric technicians (psych techs). They were responsible for overall nursing care and supervision of most of the hospital's residents including the administration of medications and treatments, observation of residents' conditions and behaviors, charting, grooming, habit training and first aid. Each program was also served by several other support staff, such as teachers, psychologists, rehabilitation therapists and social workers.

Data were collected between February and May of 1984 through participant observation, in-depth interviews and a self-administered health questionnaire.

The "High Functioning" program (or Program HF) was chosen because many administrators and staff thought that work there was especially stressful since most residents were prone to sudden and unexpected violent outbreaks. Participant observation was conducted on four of Program HF's five units (hereafter referred to as Units A, B, C, and D) approximately twice a week for one to two hours during a three and a half month period. With this technique, researchers engage directly in many of the activities of the group being studied. In this way they can see daily life carried out by people who have become relatively indifferent to a researcher's presence. Each unit had its own participant observer, a UCLA undergraduate who had received 10 weeks of training in the methods of participant observation and in-depth interviewing.

Semi-structured interviews were also conducted with 21 of Program HF's 37-day shift psych techs (57 percent). Two-thirds of those interviewed were women. Each tech interviewed, in addition to five who were not, completed the Cornell Medical Index, a self-administered health questionnaire (Brodman et al. 1949). Those interviewed were chosen on the basis of convenience, but they did not differ significantly from those not interviewed in age, sex and length of hospital service. The data obtained from these formal interviews supplemented the material collected from all unit staff during the participant observation sessions.

A coding system was developed for filing and cross-referencing the observational and interview data. Numbered coding categories were created for sources of perceived stress and satisfaction at work, and social interaction on and off the units. All field notes and interview responses were assigned one or more numbered codes and filed in the appropriate categories. Each participant observer coded her own data. All data were then crosschecked for reliability by me and the other field workers.

Each participant observer conducted the preliminary analysis of her data. This involved keeping track of themes, hunches, interpretations and trends, and validating them by systematically reading through the data. Each observer presented her analysis to the group and defended it against other possible interpretations, of modified it to account for considerations she had overlooked.

The health instrument was scored according to the manual. This required that the instrument's 195 questions be grouped into four mutually exclusive categories and sums calculated for the "yes" responses for each category and for the entire questionnaire.

Our results will be presented in four parts: sources of satisfaction and stress at work, the role of social support, the effects of gender and the data on health.

Sources of Satisfaction and Stress at Work

I can only briefly summarize the satisfactions and stresses that Program HF's psych techs reported. I want to emphasize, however, that neither stresses nor satisfactions varied significantly across the four units. Nor were there systematic gender differences in techs' reports of work-based satisfaction and stress.

Based on the literature (Fimian 1984; Sarata 1974), hospital administrators' reports and our own observations, we had anticipated that working with severely and profoundly retarded residents would be the source of a significant portion of job stress that the techs described. Instead, the techs consistently indicated that their most important and valued source of job satisfaction was the residents. This was despite the fact that techs were often victims of unexpected, violent attacks by residents, which was the only aspect of their direct care responsibilities that they did consider stressful. Rather, the psych techs felt pride or a sense of accomplishment when they saw

progress in the residents' social or intellectual development. They also enjoyed planning and participating in special activities for the residents such as holiday entertainment programs. Several said they felt personal satisfaction simply from being with the residents; others said they preferred interaction with them to their fellow staff. Most became psych techs because they wished to work with the handicapped. Opportunities to do so remained the most rewarding aspect of their work.

The stress sources psych techs most often reported stemmed therefore not from the residents but rather from techs' inability to control other critical aspects of their work. For instance, most interviewed felt that changes in hospital policies and procedures took place without regard for the impact they had on those who were responsible for implementing them. Techs also felt that they lacked the means to influence the type and amount of communication they had with hospital administrators, and that their opinions went unheard because there were no channels for them. 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 must be done. Just do it!'" The five most frequently mentioned sources of job stress to emerge were: conflicts over the planning and implementation of residents' developmental programs, techs' inability to influence the prescribing of medications, the excessive and seemingly needless quantities of paperwork for which the techs were responsible, the way that techs work schedules were determined, and the unpredictability of residents' violent behavior.

Social Support at Work

We chose not to use standardized measures of social support for this exploratory study because we feared they would be of limited value. Instead 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 kind of support they felt they needed. Unlike staff's views of satisfaction and stress, which varied little across the four units, significant variation was found in techs' definitions of social support and their expectations of coworkers.

Social support on Unit A, the most cohesive of the four, was expressed through a variety of means including helping co-workers on the job, conversation, friendship and off-the-unit potlucks, dinners and parties. Unit A techs attributed their ability to cope with job stress to broadly-based co-worker support. Said one, "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 others are real good about it. They encourage me to walk it off."

Most B techs also used work-based social support to help alleviate job stress, but they sought support primarily from a single co-worker--their group partner--and not from the wider psych tech group as Unit A techs did. This may partly have been because Unit B had an unusually high concentration of extremely violent residents who needed constant attention. This led supervisors to assign two techs to each small resident group, instead of one as was the case on the other three units.

In contrast, most Unit C techs felt their co-workers provided very limited social support. The only exception was a clique of three who regularly socialized on and off the unit and discussed personal matters. Unit D techs consistently indicated that social support was totally absent from their unit. No techs on this unit considered themselves to be friends. None socialized off the unit and those interviewed said they kept problems at work from intruding into their home lives by leaving their jobs and co-workers behind the moment they left work.

Content analysis of the data revealed that social support on the four units varied along five main dimensions: definitions of social support, the nature of unit-based conversations, expectations regarding help in emergencies, friendship patterns, and the role of the unit supervisor. Noteworthy is the fact that Unit A differed from the other three units on all five dimensions.

First, in contrast with technicians on the other three units who reported diverse definitions of social support at work, Unit A's techs held a common definition: the willingness to provide both material and emotional support. Second, the quantity and content of conversations on the four units differed. On Units B, C and D, conversation of any kind was rare, while it was almost constant on Unit A. There it covered a broad range of topics from work matters to minor personal problems to small talk. Third, technicians on Unit A said they knew they could count on their co-workers in emergencies, such as when violent episodes would erupt. Technicians on the other three units did not feel they could always count on their peers. One Unit C tech said, for instance, "Sometimes, it's like they head off the opposite way when Albert [a resident] starts to blow."

Fourth, friendship patterns on the four units also differed. In part because Unit A's techs knew they could count on their co-workers in times of need, they regarded themselves as a team. No techs on the other three units used this term or expressed the same feeling. In addition, however, social ties among Unit A's techs also extended to intermittent off-the-unit socializing. Most Unit A techs had worked together for several years, and they saw themselves in agreement on how their unit should run. On the other three units, although friendship groups of two or three were not unusual, there was no general feeling among techs that they could--or should--operate as a team. Nor were there circumstances under which all technicians from any of the other three units socialized as a group outside of work. Last, the four unit supervisors had very different managerial styles which appeared to influence the kind of help their subordinates felt they could obtain. Unit A's supervisor stood out from the rest. This was not only because she was seen by her staff as sharing their concerns and genuinely interested in their affairs, but also because she was willing to stand up to hospital administrators on her staff's behalf. Although staff on some of the other units thought well of their supervisors and brought work related problems to them when necessary, none saw their supervisors as advocates for themselves or their units.

The Role of Gender

I can make only tentative statements about the role of gender in explaining patterns of social interaction on the four units, for each had so few male techs. Units A, B, and D each had a female to male tech ratio of eight to two; on Unit C it was seven to four. But by examining the four units together we can identify some interesting trends. Overall, slightly more of the male techs were socially isolated from their peers. Yet the broader patterns of social interaction characteristic of the four units seemed to play a more powerful role than gender did in determining the quality of social relations that were found.

In other words, when male techs were isolated from their co-workers, it seemed to be for reasons other than their sex. For example, on the most cohesive unit, Unit A, the only person who felt distant from his co-workers was male. But he attributed this to the fact that he was relatively new to the unit, so that his co-workers had not yet accepted him as someone they could depend upon and trust. Unit A's other male tech had good relationships with the rest of the staff, and he socialized with them off the unit as well. Similarly, both Unit B's male techs were perceived by themselves and others to

be isolated from their peers. This compares with only one of eight female techs who felt similarly marginal. The men's social isolation, however, seems to have been caused by characteristics specific to their particular jobs. B was the unit where social ties were formed primarily with a group partner rather than with a larger tech group, and neither of these men happened to have been assigned group partners. Thus where social ties were generally dyadic, the men seem to have been isolated primarily because they lacked the same opportunities for social interaction that the others had.

On the units where few techs had meaningful social ties at work, men were as likely as women to form such ties. On Unit C, for instance, most techs of both sexes were distrusted and disliked. But the one clique that did form consisted of two women and one man. Similarly, on Unit D, no techs of either sex liked one another or felt close. The two male techs did look to one another for help more consistently than they did to any of the female techs, but they did not express positive feelings about one another. Both described the relationship as one of convenience. But there was also distance and distrust among all female techs on this unit.

Health Results

The Cornell Medical Index was used to assess the psych techs' health. Means, medians and ranges for each unit were calculated for the entire instrument and for the sections on Bodily Symptoms and Behavior, Mood and Feeling, the parts of the instrument presumed to be the most sensitive indicators of stress. The Mann-Whitney U test showed the difference in scores between Unit A and the other three to be significant at the .05 level. Means, medians, and ranges were also calculated by gender. Values were slightly higher for the female techs but the differences did not reach statistical significance.

DISCUSSION

Psych techs on the four units worked in very similar environments, had responsibilities for comparable types of residents, and reported similar work satisfactions and stresses. Yet social support varied dramatically, ranging from Unit D where there were no ties among co-workers, to Unit A where we found cohesion on the unit as a whole. Techs' expectations for social support at work also varied. In contrast with the rest, Unit A's techs held a common definition of social support which allowed them to articulate and achieve commonly held goals. Unit A's techs therefore may have found their needs for work-based social support more readily met because they agreed on what social support involved. In contrast, techs on the other three units may have been less apt to feel their co-workers met their social support needs because they differed on what this concept meant.

On all four units, work-based social support was minimally defined as providing coworkers help when it was sought. But on the cohesive unit, it also meant teamwork in a broader sense, and the resolution of unit-wide problems by the staff as a group. Techs who worked on the cohesive unit were also in better health. These preliminary data do not allow us to determine all of the reasons why this association occurred. The strong support Unit A's supervisor expressed for her staff and her willingness to act as their advocate undoubtedly contributed to creating a socially cohesive unit. Also, the fact that the group was rather stable is likely to have facilitated the development of dependable ties at work.

Gender differences did not appear to play an important role in explaining reported variation in sources of perceived job stress, the use of social supports at work or staff health. This may have been because the overwhelming

majority of the staff on all four units were women, thereby overpowering any variation that might have been seen had there been more male techs present. Just as women who work in male dominated environments seem to internalize male values and patterns of social interaction, men who work in female dominated settings appear to adopt the female defined patterns.

How social ties at work serve to buffer the negative effects of job stress on health is still unknown. We might theorize that spending day after day with co-workers who hold common norms, values and expectations can create a sense of belonging and coherence that can enhance personal stability and overall health. But generalizations from these exploratory data should be cautiously made. Further investigation of the circumstances under which work-based friendships can translate into health gains for women workers deserves more research attention, both for the light such work could shed on the relationship between social support and health status, and for the insights it could provide in our broader quest to understand the determinants of women's health.

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