Staff stress and job satisfaction at a children’s hospice

H WOOLLEY,* A STEIN,† G C FORREST,* AND J D BAUM‡

*Park Hospital for Children, Oxford, †Department of Psychiatry, University of Oxford, Warneford Hospital, and ‡Institute of Child Health, Royal Hospital for Sick Children, Bristol

SUMMARY A study of staff stress and job satisfaction was undertaken in a children’s hospice. In addition factors were investigated which might be stressful or which helped staff to manage in difficult circumstances. Three quarters were under comparatively little stress and in general showed very few psychological symptoms but a distinct subgroup were under a great deal of stress. A number of factors, notably recent personal bereavement and unresolved grief about a death that had occurred before they came to work at the hospice, distinguished this small group. Job satisfaction was generally high.

The main sources of stress were: the sense of impotence staff felt when they were unable to relieve perceived needs or distress; dealing with negative responses in families, and conflicts within the staff group. The most important mitigating factors were: the informal support that staff provided for each other in this small cohesive working unit, the homelike atmosphere of the hospice, and the diversity of professional and personal skills among the staff group. The implications of these findings for reducing stress among staff dealing with dying people are discussed; this includes not only staff on paediatric wards, intensive care and neonatal units, but also community paediatric nurses.

Medical concern for people in occupations that impose unusual degrees of stress is not a new phenomenon. There has recently been an increasing interest in the care of the terminally ill together with a growing recognition that staff working with the dying and their families may experience particular stress. Initial studies were concerned with staff in intensive care units1 and special care baby units.2 Subsequent studies focused on those caring for dying adults,3–8 and most recently on staff caring for dying children and their families.9 10

Vachon7 argues that there are a number of reasons why staff working with terminally ill patients are especially at risk. For example, such work may attract staff with high ideals who are in danger of entertaining unrealistic expectations; constant confrontation with death may evoke unresolved past losses and cause grief reactions or unrecognised and unacknowledged depression, and regular contact with death can diminish ordinary relationships and have an adverse effect on friendships, marriages, and family life. Vachon also found that certain personality problems, as well as close identification with individual patients, were associated with a lot of stress. Lattanzi10 noted the emotional stress for staff arising from the sense of powerlessness associated with being unable to save the life of a dying child or eliminate the pain of bereavement.

Maguire8 pointed out that there are communication problems in dealing with patients who are terminally ill, and in particular noted the use of distancing tactics by staff. For example, cues from patients may be ignored, and patient distress minimised by such tactics as inappropriate cheerfulness and premature or false reassurance.

The first children’s hospice in the United Kingdom was opened in 1982 and provided an opportunity to investigate some of the issues raised above. This hospice, the nature and evolution of which has been described elsewhere,11 offers respite and terminal care as a home away from home for children suffering chronic life threatening and terminal illnesses. The most common illnesses among children in this hospice are a wide range of neurodegenerative and metabolic disorders, muscular dystrophy, and a small group with neoplasms predominantly of the central nervous system. The hospice is a purpose built eight bedded unit and has space to accommodate families and children.

The aims of our study were to examine: firstly, the degree of stress experienced by staff caring for children and their families; secondly, those factors...
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which staff found stressful, and those which helped them to manage in difficult circumstances; thirdly, degrees of, and factors associated with, job satisfaction.

Subjects and methods

At the time of the study 27 staff were employed at the hospice for the direct care of the children and their families. This care included sharing all domestic duties such as washing, cleaning, shopping, and cooking. Of the 27 staff, 24 took part in the study, two declined, and one was on sick leave. Of the 24 staff interviewed, ages ranged from 22–55 years, 14 being between 30 and 40. Four staff lived on their own, 19 with partners, and one with parents. There were only two men. Sixteen worked full time and eight part time, five of the latter working only on night shifts. Twelve were qualified nurses (RSCN), five had qualifications in teaching, physiotherapy, or social work, and six had no formal qualifications. There was one general practitioner who served the hospice and was attached to a local group practice.

The assessment entailed interviewing each member for about one and a half hours during which a semistructured questionnaire was given and the staff were asked to complete Goldberg's 60 item general health questionnaire. The general health questionnaire (a well established self report questionnaire) measures psychological symptoms, in particular somatic symptoms, anxiety and insomnia, social dysfunction, and severe depression. A score of 11 is generally taken as the cut off point above which the number of symptoms is considered significant. General health questionnaire scores were used together with the amount of time that staff spent on sick leave, and the turnover rate of staff as indices of stress. Job satisfaction was assessed by a seven point rating scale with four being the mode, one indicating little, and seven indicating a great deal of satisfaction.

The semistructured questionnaire was used to investigate a variety of aspects of hospice life; subjects were asked what led to job satisfaction, what they found stressful, and what mitigated stress in the following areas: different types of illness, specific symptoms, and death of a child; factors relating to families of children; personal characteristics and circumstances that helped or hindered them; layout and organisation of the hospice; and staff support and training.

At the end of the interview a clinical assessment was made by the interviewer of the extent of unresolved grief concerning a death of a relative or friend that had occurred more than a year previously, and before beginning work at the hospice.

This was assessed by taking into account a high degree of expressed emotion, together with immediacy of recall and the lack of an apparent blunting of emotion with time when discussing the deceased person.

Results

INDICES OF STRESS

The general health questionnaire scores ranged from 0–39 with 18 (75%) staff scoring below the cut off point of 12 (range 0–9; median 3) and six (25%) scoring above that point (range 19–39; median 33) (table 1). Thus a distinct group with high general health questionnaire scores was identified.

The main symptoms among the high scorers (table 2) were anxiety and insomnia, and to a lesser degree somatic symptoms and social dysfunction. Symptoms of depression were rarely reported. When asked about death among family and friends (table 3), four out of the six high scorers on the general health questionnaire compared with three of the 18 low scorers reported loss in terms of the death of a close relative or friend in the preceding year (Fisher's test of exact probability <0.05).

On clinical assessment, four of the high scorers showed substantial unresolved grief, compared with

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<tr>
<th>General health questionnaire score</th>
<th>No of staff</th>
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<tr>
<td>0</td>
<td>7</td>
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<tr>
<td>1</td>
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<td>39</td>
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<table>
<thead>
<tr>
<th>Mean No in each group</th>
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<tbody>
<tr>
<td>High scores (n=6)</td>
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<tr>
<td>------------------------</td>
</tr>
<tr>
<td>Somatic symptoms</td>
</tr>
<tr>
<td>Anxiety and insomnia</td>
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<td>Social dysfunction</td>
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<td>Severe depression</td>
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only one low scorer (Fisher’s test of exact probability <0.05). In total, five of six high scorers had lost a relative or close friend in the past year, or showed substantial unresolved grief, or both, compared with only three out of 18 low scorers. (Fisher’s test of exact probability <0.01).

Each member of staff had an average of 6.2 days sick leave a year. This compared with an average of 11.5 days sick leave for nursing staff on nine paediatric wards in South London (M Rose, unpublished observations). Twenty one (88%) had worked at the hospice for more than two years, 13 (54%), since it opened four years before this study, and three (12%) had worked there for less than two years.

JOB SATISFACTION RATING
On the seven point rating of current job satisfaction staff scores ranged from 3–7 with a median of 6. Staff reported that their satisfaction with the job remained high despite experiencing of times of great stress.

STRESSFUL AND MITIGATING FACTORS IN HOSPICE LIFE
Different types of illness, specific symptoms, and death of a child. Many staff said that it was not so much the particular illness that upset them but symptoms or behaviour that seemed uncontrollable. Uncontrollable symptoms created much stress while the ability to relieve a symptom or distress was extremely rewarding. Witnessing a child’s pain was rated by 20 staff (83%) as the most stressful aspect, and perceiving a child’s mental distress was a close second for 15 staff.

A number of conditions were found to be stressful for different reasons. Eight (33%), found the neurodegenerative disorders particularly distressing because of the slow diminishing quality of life, and the effect on the family. Five (20%) found muscular dystrophy in teenagers distressing because of the increasing physical deterioration in the presence of intact intellectual faculties. A further five found the neoplastic conditions distressing, because cancer was seen as a disease that their own families were more likely to suffer from. At the same time, however, staff often gained satisfaction from performing specific tasks (for example, giving pain relief) which comforted patients.

Staff felt particularly stressed by an expected death that did not occur, with all its attendant uncertainty and unpredictability. Furthermore, not being directly involved (that is, not being the primary carer) was difficult for staff who had been close to child and family; as one said ‘to merely observe is to be impotent’. Staff felt that they too needed an opportunity for parting and the rituals of separation.

Factors related to the families of children. A number of factors were reported by staff to be especially difficult to manage. In particular, 10 (42%) found it difficult to cope with certain negative responses of families, especially anger (hidden or overt), helplessness, and the occasional criticism of staff. Grieving relatives who did not share or show their grief (particularly some fathers and grandparents) left staff members uncertain as to how to relate to them, and therefore feeling helpless. A third of the staff reported identifying closely with individual parents or children, particularly if the parent was a similar age to the staff member or the children were similar in age or in some other way to their own children.

Personal characteristics and circumstances which helped or hindered staff. Within the hospice, 19 (80%) staff reported that difficulties in staff communication and inter-relationships were an important source of stress. Conversely, all staff felt that informal staff support was the most important factor which helped them to cope.

Staff indicated that having a sense of humour, knowing one’s own limitations and what skills one had to offer, having a philosophy of life that helped them through good and bad times, as well as having supportive friends and relations, were the most
important factors enabling them to function effectively at work. Factors which created some difficulty were balancing home and work commitments, cutting off at the end of the day and allowing themselves time off, and having enough energy for friends and family. Some staff struggled with the problem of how to avoid making the ordinary events in life seem trivial and banal in the face of the serious life and death events of the hospice.

**Layout and organisation.** All the staff emphasised how much they valued the hospice’s informal homelike quality. Sharing of domestic duties and decisions brought them closer together, and enhanced the mutual support and friendship within the team which they cited as a crucial ingredient of job satisfaction. Staff valued the lack of a rigid hierarchy and red tape.

The general consensus was that catering for a maximum of eight resident children at any one time together with accompanying relatives (this could involve 20 or more people at a time) was the upper manageable limit. As one member of staff commented ‘we are in danger of losing the cohesive family like personal care atmosphere once we have more people than can sit comfortably around the (large circular) dining table’.

Staff valued having time to share with families and colleagues, especially to enable them to respond to individual needs and to continue the child’s preferred personal routine.

**Staff support and training.** All staff said that informal staff support was the most important factor in helping them to cope with the work they faced. Half the staff regularly attended each of the two weekly staff group meetings; of these 60% found the regular staff business meetings helpful, and 80% valued the support group meeting with a visiting consultant psychiatrist. Several staff commented that such meetings could be uncomfortable and even painful at times, but noted that enjoyment was quite different from usefulness and the sessions that tackled the more difficult and uncomfortable issues often proved the most helpful in the long run. Seventeen (70%) carers drew strength from religious beliefs, but this support stemmed more from personal convictions such as belief in an after life than from formal religious connections.

While staff valued their professional qualifications, they particularly identified the contribution of life experience in equipping and helping them to meet the varied demands of their work.

**Discussion**

Our findings suggest that at this hospice comparatively few of the staff experienced high degrees of stress but the importance of the 25% who did should not be underestimated in view of the nature of the work. Specific factors concerning recent personal bereavement and unresolved grief from the past distinguished this small group of high general health questionnaire scorers from the rest of the staff. Although the total number of subjects was comparatively small, the findings have some general implications for both staff selection and staff support along the lines of previous recommendations. In particular when selecting staff it is important to be alert to the possible vulnerability of potential staff carrying unresolved grief, as great distress can be rekindled when a current trigger event echoes back to and resurrects a sense of loss. Furthermore, specific consideration and support needs to be given to staff who experience current personal bereavement. The very nature of the work serves as a constant reminder of their loss, and may interfere with their own natural grieving. In particular, counselling and additional time off may be necessary.

The staff were able to pinpoint a number of important issues which they found stressful. Firstly, when staff felt unable to relieve perceived needs, symptoms, or distress it left them feeling helpless. Thus when appointing staff it may be important to look for qualities of understanding and strength that will enable a staff member to live with another’s distress without feeling too diminished by a sense of helplessness.

Secondly, the negative attitudes of some families which manifested as anger or criticisms often made staff uncertain how they should react and left them feeling undermined and distressed. It seems essential that a good hospice support system needs to be fostered together with special training to aid the staff in understanding human responses and to prevent them inadvertently resorting to the distancing tactics described by Maguire. Staff may also need help in avoiding inappropriate overinvolvement with family members.

Thirdly, problems with relationships within the staff group could be an important source of stress. Overall it seems that the cohesiveness of the staff group in such a small hospice is an important source of coping and therefore of stress when cohesiveness is threatened by inter staff conflict. As Mount and Voyer point out, however, any group claiming to work as a team should show their battle scars: ‘if they don’t have scars they haven’t worked as a team’.

The staff were able to identify a number of issues which they found helpful, supportive, and rewarding. These included the existence of supportive
interpersonal staff relationships, the homelike physical environment, and the diversity of professional and personal skills among the staff group. The ability to meet and relieve distress or any perceived need was repeatedly emphasised by staff as important for job satisfaction, just as an inability to do so led to staff feeling stressed.

Outside the hospice, staff felt they needed the support of family or friends and enough time off to enjoy outside interests in order to maintain a balanced perspective at work. Furthermore, they needed time and space both in and out of work to come to terms with important events they had witnessed, such as death and the stress experienced by families.

Two caveats should be mentioned when drawing our conclusions. Firstly, the comparatively small number of staff (24) limits our conclusions, although our findings are buttressed by their consistency with other studies. Secondly, the nature of this hospice’s evolution together with the continued inspiration and involvement of a charismatic founder adds a unique quality to the hospice and its life.

The findings of this study have implications for groups of staff caring for terminally ill children, including those on paediatric wards, neonatal and intensive care units. Together with the recent upsurge of interest in children’s hospices, however, there has been a concurrent movement towards caring for the dying child at home. Should this become a greater trend the issues raised by this study will need to be tackled in the community. For instance, a community paediatric nurse would need a base where he or she could draw support and understanding to help cope with the stress inherent in the work. Thus while some families may prefer their children to be cared for at home, the nurse may find it more difficult. These are issues which may need to be considered by educators in the field especially those concerned with paediatric nurse training.

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References

Correspondence to Mrs H Woolley, Park Hospital for Children, Headington, Oxford OX3 7LQ.

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