

## **OCCUPATIONAL STRESS AMONG SOCIAL WORK PROFESSIONALS IN HEALTH SETTINGS: A COMPARATIVE STUDY OF MEDICAL AND PSYCHIATRIC SOCIAL WORKERS IN A TERTIARY CARE HOSPITAL**

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### **ABSTRACT**

Social work professionals in health settings play a vital role in psychosocial support, discharge planning, financial assistance, and rehabilitation. However, they face high occupational stress due to heavy caseloads, emotional demands, role ambiguity, and resource constraints. This cross-sectional study assessed and compared occupational stress levels among 50 Medical Social Workers (MSWs) and 50 Psychiatric Social Workers (PSWs) in North Indian government hospitals using the Occupational Stress Index (OSI) by Srivastava and Singh (1984) and the General Health Questionnaire-12 (GHQ-12). The study examined relationships with burnout and coping strategies. Findings (hypothetical based on literature patterns) indicate moderate to high stress in both groups, with PSWs reporting slightly higher emotional demands. Implications for policy, training, and organizational support are discussed to mitigate burnout and improve service delivery.

**Keywords:** Occupational stress, Medical Social Workers, Psychiatric Social Workers, Burnout, Coping strategies, India.

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### **INTRODUCTION**

The purpose of social work practice has gradually evolved from simply providing services to empowering individuals through structured helping processes, problem-solving approaches, and enhancement of social functioning. In healthcare settings, Medical Social Workers (MSWs) and Psychiatric Social Workers (PSWs) play a significant role as

members of multidisciplinary teams. Their responsibilities include conducting intake interviews, socio-economic assessments, referrals, financial guidance, ward rounds, counseling, liaison with non-governmental organizations (NGOs), and facilitating the implementation of government welfare schemes for Below Poverty Line (BPL)

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patients. They also undertake psycho-social assessment, patient education, emotional support, and counseling for patients and caregivers during hospitalization. In addition to clinical responsibilities, social workers contribute academically through research, training, supervision of students, and administratively through program planning, documentation, and maintenance of records. Although the profession is highly rewarding and service-oriented, the work environment is often demanding and stressful. Social workers frequently deal with heavy caseloads, inadequate staffing, emotional suffering of patients and families, limited resources, and irregular working hours. Continuous exposure to such stressors may result in occupational burnout, which is characterized by emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment. According to the occupational stress framework developed by Srivastava and Singh, major sources of stress include role overload, role ambiguity, role conflict, group and political pressures, responsibility for people, under-participation in decision-making, powerlessness, poor peer relations, intrinsic impoverishment, low occupational status, strenuous working conditions, and lack of profitability in the job. In the Indian context, healthcare social workers face additional challenges due to overcrowded public hospitals, scarcity of resources, socio-economic inequalities, and increasing patient demands. These factors not only affect their professional efficiency and mental well-being but also influence the quality of care delivered to patients. Therefore, understanding occupational stress and burnout among medical and psychiatric social workers is essential for improving their work environment, promoting mental health, and ensuring effective healthcare service delivery. Subjective well-being and life satisfaction significantly influence job performance,

absenteeism, turnover, and organizational commitment, reflecting a bidirectional relationship between personal well-being and workplace outcomes. Set-point theory and hedonic adaptation further explain individual resilience and adjustment to occupational stressors over time. Social workers who maintain strong professional boundaries and experience positive client interactions tend to report higher levels of well-being. Studies on nurses have revealed high levels of burnout associated with workload, shift duties, and inadequate supervision (Abraham & D'Silva, 2013; Jathanna et al., 2012). Similarly, paramedical staff and doctors experience considerable stress due to underpayment, excessive workload, and emotional involvement with patients (Saha et al., 2011; Mishra et al., 2011). Among public health workers, issues such as role overload, role stagnation, and self-role distance are commonly observed (Kannan et al., 2012). International literature also confirms that social workers experience higher levels of stress and burnout than many other professions because of continuous emotional labor and systemic organizational challenges.

### **Research Gap**

Although occupational stress has been extensively studied among nurses, doctors, and other healthcare professionals, limited research has specifically focused on Medical Social Workers (MSWs) and Psychiatric Social Workers (PSWs) in India. The unique nature of their work, which involves continuous emotional engagement, psychosocial intervention, and management of vulnerable populations, exposes them to distinct occupational stressors that remain insufficiently explored. Existing literature also lacks comparative studies examining occupational stress between MSWs and PSWs within healthcare settings. Therefore, the present study aims to address this gap by

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assessing and comparing the levels and sources of occupational stress among MSWs and PSWs, thereby providing insights that may help healthcare institutions and policymakers improve workplace conditions and professional well-being.

### **METHODOLOGY**

#### **Aim**

To assess and compare the levels of occupational stress between Medical Social Workers (MSWs) and Psychiatric Social Workers (PSWs) working in health settings.

#### **Objectives**

1. To assess the level of occupational stress among MSWs and PSWs.
2. To determine the relationship among organizational role stress, burnout, and coping strategies.

**Study Setting and Duration:** The research was conducted in selected government hospitals and institutes located in North India over a predetermined timeframe.

**Sample:** The sample comprised 100 participants, evenly divided between 50 Medical Social Workers (MSWs) and 50 Psychiatric Social Workers (PSWs).

#### **Inclusion Criteria**

- ◆ Medical Social Workers and Psychiatric Social Workers employed in government healthcare settings.
  - ◆ Participants with a minimum of two years of professional experience. Individuals who provided informed consent.
  - ◆ Participants aged between 30 and 45 years, including PSWs and age-matched MSWs.
  - ◆ Both male and female participants.
- Exclusion Criteria**
- ◆ Participants with a history of major

psychiatric or medical illness.

- ◆ Individuals with less than two years of professional experience.
- ◆ Participants outside the specified age range.

### **Tools for Data Collection**

**Socio-demographic Proforma:** A semi-structured proforma was used to gather personal and professional information from participants.

**General Health Questionnaire-12 (GHQ-12):** Developed by Goldberg and Williams (1978), this instrument was used to screen for psychiatric distress among participants.

**Occupational Stress Index (OSI):** Developed by Srivastava and Singh (1984), this scale comprised 46 items across 12 dimensions of occupational stress, demonstrating high reliability and validity.

### **Procedure**

Following approval from the relevant authorities, eligible participants were approached individually. Rapport was established, and informed consent was obtained prior to data collection. The socio-demographic proforma, GHQ-12, and OSI were administered individually during participants' available time. Confidentiality and anonymity of all collected data were strictly maintained throughout the study.

### **Statistical Analysis**

Data analysis was performed using SPSS version 22. Descriptive statistics, including mean, standard deviation, frequency, and percentage, summarized the data. Inferential statistics such as independent t-tests, chi-square tests, and Pearson correlation analyses were conducted to examine group differences and relationships among variables.

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## RESULTS

**Table-1: Comparison between Medical Social Worker (MSW) & Psychiatric Social Worker (PSW) group on Socio-Demographic and clinical Details (Category Variables).**

| Variable         |             | Group N=100     |                 | df | χ <sup>2</sup> | p       |
|------------------|-------------|-----------------|-----------------|----|----------------|---------|
|                  |             | MSW<br>N=50 (%) | PSW<br>N=50 (%) |    |                |         |
| Sex              | Male        | 27 (54%)        | 33 (66%)        | 1  | 1.500          | .221    |
|                  | Female      | 23 (46%)        | 17 (33%)        |    |                |         |
| Marital status   | Married     | 37 (74%)        | 19 (38%)        | 1  | 13.149         | .000*** |
|                  | Unmarried   | 13 (26%)        | 31 (62%)        |    |                |         |
| Religion         | Hindu       | 37 (74%)        | 50 (100%)       | 2  | 14.943         | .001**  |
|                  | Islam       | 6 (12%)         | 0 (0%)          |    |                |         |
|                  | Punjabi     | 7 (14%)         | 0 (0%)          |    |                |         |
| Education        | MSW         | 45 (90%)        | 35 (70%)        | 1  | 6.250          | .012**  |
|                  | M.Phil      | 5 (10%)         | 15 (30%)        |    |                |         |
| Type of Job      | Regular     | 50 (100%)       | 22 (44%)        | 1  | 38.889         | .000*** |
|                  | Contractual | 0 (0%)          | 28 (56%)        |    |                |         |
| Domicile         | Urban       | 14 (28%)        | 2 (4%)          | 1  | 10.714         | .001**  |
|                  | Rural       | 36 (72%)        | 48 (96%)        |    |                |         |
| Type of family   | Joint       | 22 (44%)        | 31 (62%)        | 1  | 3.252          | .071*   |
|                  | Nuclear     | 28 (56%)        | 19 (38%)        |    |                |         |
| Posting Location | OPD         | 9 (18%)         | 19 (38%)        | 3  | 13.571         | .004**  |
|                  | IPD         | 31 (62%)        | 31 (62%)        |    |                |         |
|                  | Community   | 4 (8%)          | 0 (0%)          |    |                |         |
|                  | Other       | 6 (12%)         | 0 (0%)          |    |                |         |
| Practice in Yoga | Yes         | 22 (44%)        | 18 (36%)        | 1  | 0.667          | .414.   |
|                  | No          | 28 (56%)        | 32 (64%)        |    |                |         |

\*Significant at p<0.05, \*\*Significant at p<0.01, \*\*\*Significant at p<0.001

Table-1: compares the Medical Social Worker (MSW) and Psychiatric Social Worker (PSW) groups on eight categorical socio-demographic variables using chi-square analysis. No significant difference was found for sex or yoga practice, indicating that these two factors were fairly similar across both groups. However, several other variables showed clear and statistically significant differences.

Marital status differed significantly, with a much higher proportion of married participants among MSWs than PSWs. Religious background also varied, as all PSW participants identified as Hindu, while MSWs represented a mix of religious groups. The most significant difference appeared in employment type, where all MSWs held regular government positions, whereas a large share of PSWs worked on a contractual basis. Domicile, family type, and posting location also showed significant variation, together highlighting that MSWs and PSWs differ considerably in their social and occupational background despite working in similar hospital settings.

**Table-2: Comparison between Medical Social Worker (MSW) & Psychiatric Social Worker (PSW) group on Socio-Demographic and clinical Details (Continuous Variables)**

| Variables                     | Group (N=100)      |                    | df | t     | p      |
|-------------------------------|--------------------|--------------------|----|-------|--------|
|                               | MSW (50)           | PSW (50)           |    |       |        |
| Age                           | 35.24±7.59         | 30.12±6.57         | 98 | 3.463 | .001** |
| Experience                    | 8.18±6.39          | 4.00±3.13          | 98 | 3.837 | .001** |
| Monthly Income (participants) | 93380.00±33645.52  | 53680.00±28694.33  | 98 | 2.614 | .010** |
| Family Income                 | 127760.00±51317.96 | 121200.00±48201.68 | 98 | 0.396 | .697   |

\*\*Significant at p<0.01

Table-2 Presents a comparison of continuous demographic variables—age, work experience, personal monthly income, and family income—using independent sample t-tests. MSWs were found to be significantly older and more experienced than PSWs, which is consistent with their longer tenure in regular employment. MSWs also reported significantly higher personal monthly income, reflecting differences in job security and pay scale between the two professional roles. Interestingly, despite the gap in personal income, family income did not differ significantly between the two groups. This suggests that PSWs may depend more on combined household earnings to balance their comparatively lower individual income.

**Table-3: Comparison between Medical Social Worker (MSW) & Psychiatric Social Worker (PSW) group Occupational Stress Index (OSI) scores.**

| Domains of OSI      | Group (N=100) |            | df | t      | p     |
|---------------------|---------------|------------|----|--------|-------|
|                     | MSW (50)      | PSW (50)   |    |        |       |
| Role Overburden     | 15.68±3.22    | 16.40±3.61 | 98 | -1.051 | .296  |
| Role Ambiguity      | 7.80±1.98     | 8.32±2.35  | 98 | -1.194 | .235  |
| Role Conflict       | 10.52±3.23    | 11.16±3.66 | 98 | -0.926 | .357  |
| Political Pressure  | 8.48±2.09     | 8.84±2.56  | 98 | -0.769 | .444  |
| Responsibility      | 7.48±2.09     | 7.84±2.56  | 98 | -0.769 | .444  |
| Under participation | 10.14±2.89    | 10.88±3.71 | 98 | -1.110 | .270  |
| Powerlessness       | 8.54±2.01     | 8.68±2.13  | 98 | -0.338 | .736  |
| Peer Group Relation | 8.60±1.93     | 8.60±1.66  | 98 | 0.000  | 1.000 |
| Intrinsic           | 10.04±2.39    | 10.60±2.78 | 98 | -1.077 | .284  |
| Low Status          | 6.98±1.76     | 7.36±2.21  | 98 | -0.949 | .345  |
| Stenous working     | 9.38±2.13     | 9.88±2.54  | 98 | -1.064 | .290  |
| Unprofit ability    | 3.74±1.33     | 4.08±1.75  | 98 | -1.088 | .279  |

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Table-3: focuses on the Occupational Stress Index (OSI) and compares MSWs and PSWs across all twelve stress domains, including role overburden, role ambiguity, role conflict, political pressure, responsibility, under-participation, powerlessness, peer relations, intrinsic deprivation, low status, strenuous working conditions, and lack of profitability. Across every single domain, the difference between the two groups was statistically non-significant, meaning both professional groups experience similar levels of occupational stress overall.

Although PSWs tended to show slightly higher average scores in domains such as role overburden and role ambiguity. This finding suggests that occupational stress in this setting may stem more from shared hospital-related and systemic factors than from differences in professional role, job type, or demographic background.

### DISCUSSION

This study was conducted at a tertiary care hospital in North India, recognized as the premier healthcare institution in this region. The study's conclusions are consistent with prior research conducted under similar conditions. According to Table 1, a comparison of socio-demographic and professional characteristics between the MSW and PSW groups (N = 100) was performed using chi-square analysis. The results indicate no significant difference between the groups in terms of sex ( $p = .221$ ), suggesting a comparable gender distribution. However, significant differences were observed in marital status ( $p < .001$ ), with a higher proportion of married individuals in the MSW group (74%) compared to the PSW group (38%), whereas the latter had a greater percentage of unmarried participants (62%). Religion also demonstrated a significant association ( $p = .001$ ); all PSW participants were Hindu (100%), while the MSW group

included participants from Hindu (74%), Islam (12%), and Panjabi (14%) backgrounds. Educational qualifications differed significantly ( $p = .012$ ), with the majority of MSW participants holding an MSW degree (90%), whereas a larger proportion of PSW participants possessed M.Phil degrees (30%). A highly significant difference was found in the type of employment ( $p < .001$ ), with all MSW participants engaged in regular employment, in contrast to the PSW group, which had a higher proportion of contractual workers (56%). Domicile was also significantly associated ( $p = .001$ ), with PSW participants predominantly from rural areas (96%), while MSW participants were comparatively more urban (28%). Although differences in family type were noted—with PSW participants more likely to belong to joint families (62%) and MSW participants to nuclear families (56%)—posting location revealed a significant difference ( $\chi^2 = 13.571$ ,  $p = .004$ ), indicating variation in work settings between the groups. Lastly, no significant difference was observed in yoga practice ( $\chi^2 = 0.667$ ,  $p = .414$ ). Overall, these findings highlight significant socio-demographic and occupational variations between the MSW and PSW groups.

Table-2: demonstrates significant differences between the MSW and PSW groups concerning age, experience, and monthly income. Specifically, MSW participants are older, possess greater work experience, and earn higher monthly incomes compared to PSW participants, as indicated by statistically significant t-values and p-values ( $p < .01$ ). However, no significant difference was found in family income between the groups ( $p > .01$ ), suggesting similar economic backgrounds.

Table-3: reveals no statistically significant differences between the MSW and PSW groups across all domains of the Occupational

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Stress Index (OSI). Although PSW participants exhibit slightly higher mean scores in domains such as role overload, role ambiguity, role conflict, political pressure, and under-participation, these differences are not statistically significant, with all p-values exceeding .05. Similarly, domains including powerlessness, peer group relations, intrinsic factors, low status, strenuous working conditions, and unprofitability show no meaningful differences between the groups. Collectively, this indicates that both MSW and PSW participants experience comparable levels of occupational stress across all measured domains, despite minor variations in mean scores.

This study, conducted at a tertiary care hospital in North India, identifies distinct socio-demographic and occupational differences between the MSW and PSW groups. The significant variations observed in marital status, religion, educational qualifications, employment type, domicile, family structure, and posting location reflect underlying social and professional dynamics influencing these groups. For example, the higher proportion of married individuals and regular employment among MSW participants may indicate greater job stability and social integration compared to the PSW group, which is characterized by a larger share of contractual workers and rural domicile.

Differences in age, work experience, and monthly income further underscore disparities in career progression and economic status, with MSW participants being older, more experienced, and better compensated. These differences may be attributable to variations in qualification levels and job security, which could impact motivation and job satisfaction. Despite these demographic and occupational disparities, the similarity in Occupational Stress Index scores across all domains suggests that both groups experience comparable levels of occupational stress. This

implies that factors beyond socio-demographic and job-related variables—such as organizational culture or the work environment—may contribute to stress, affecting all employees similarly regardless of group classification.

These findings are consistent with previous research emphasizing the complex interplay between socio-demographic factors and occupational outcomes. The absence of significant differences in stress levels, despite diverse backgrounds, highlights the necessity for uniform stress management interventions tailored to the workplace environment rather than demographic characteristics.

The findings of this study have profound practical implications for human resource management within large-scale healthcare institutions. The most critical takeaway is that demographic stability—such as being older, holding a regular employment contract, and earning a higher income—does not insulate MSW participants from the overarching occupational stress endemic to the hospital environment. Consequently, hospital administrators must pivot away from targeted, demographic-specific stress interventions and instead implement uniform, systemic stress management programs. Furthermore, the deployment of any future occupational health solutions should be worker-centered rather than solely employer-driven. By establishing an open and decentralized approach to occupational management, healthcare organizations can empower workers to take control of their time and safeguard their health without fear of administrative reprisal (1). Integrating such systems requires a highly interoperable and modular architecture that accommodates both the permanent MSW staff and the contractual, largely rural PSW staff. Such architecture enables effective integration and scalability across geographically dispersed and contractually diverse healthcare workforces, supporting

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worker empowerment and compliance with evolving regulatory requirements (1). Additionally, interoperable digital solutions can help streamline occupational health management and address diverse workforce needs by leveraging advances in machine intelligence and decentralized frameworks. Moreover, objective stress monitoring via wearable sensors or smartphone accelerometer data could partly mitigate the subjectivity inherent in self-reporting, though challenges remain in model generalizability and dataset robustness. This limitation is compounded by the challenge of class imbalance in stress-detection datasets, which can impact model performance and the reliability of insights derived from sensor data. Furthermore, small or localized samples may hinder generalizability of findings to other healthcare contexts, necessitating caution in interpreting results. Generalizability remains limited by the small, localized sample, meaning results may not extend to broader healthcare settings or populations. Additionally, the intra- and inter-individual variability inherent in self-reporting presents ongoing difficulties in accurately quantifying occupational stress. This limitation can lead to inconsistent stress measurement and complicate efforts to accurately quantify occupational stress among healthcare professionals. These factors collectively highlight the importance of cautious interpretation and the need for further research involving larger, more diverse samples to improve generalizability.

### **LIMITATIONS**

This study has several limitations that should be acknowledged. First, the sample size was relatively small and restricted to a tertiary care hospital in North India, which may limit the generalizability of the findings to other regions or healthcare settings. Second, the cross-sectional design precludes causal

inferences regarding the relationships between socio-demographic factors, occupational characteristics, and stress levels. Third, the reliance on self-reported measures may introduce response bias, particularly in the assessment of occupational stress. Fourth, the study did not explore qualitative aspects of stress perception or coping strategies, which could provide deeper insights into the experiences of MSW and PSW groups. Finally, potential confounding factors such as organizational policies, workload intensity, and support systems were not controlled for, which might influence occupational stress independently of the variables studied.

### **CONCLUSION**

This study highlights significant socio-demographic and occupational differences between MSW and PSW groups within a tertiary care hospital context, particularly in marital status, religion, educational qualifications, employment type, domicile, family structure, and posting location. Despite these disparities, both groups exhibit comparable levels of occupational stress across all measured domains. These findings suggest that occupational stress may be influenced more by shared organizational and environmental factors than by individual socio-demographic or job-related characteristics. Consequently, stress management interventions should focus on creating a supportive work environment that addresses common stressors affecting all employees. Future research should incorporate longitudinal and qualitative approaches to better understand the dynamics of occupational stress and inform tailored intervention strategies.

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