Additional reading for Session 4: Psychological aspects of stress and coping

Stress
Dr Craig A. Jackson BSc MSc PhD C.Psych
Senior Lecturer in Occupational Psychology

Definition:
The term “Psychosocial Hazard” (to describe any factor that may cause distress or psychological harm) is more well-known than ever before. This has led to a widely held belief that employees must be free from psychological and mental harm as well as from physical harm. Statistics suggest that the psychosocial well-being of employees is getting worse, partly due to increasing awareness of such workplace issues, and partly due to workplaces being perceived as more potentially psychologically harmful than ever before.

Epidemiology:
Health and Safety Executive figures show half a million people in the UK believe stress makes them ill, with up to 5 million claiming they suffer from stress at work, with approximately 13 million working days lost to stress in 2004/2005.

Causes:
It is not occupations involving routine danger or extraordinary events that induce stress in employees, but it is more likely to be the mundane offices or ordinary workplaces, with on-going / long-term psychosocial hazards and risk factors posing greater stress-risks. Several factors can be identified in the workplace which are potential sources of stress for individual workers. Some of these problems are potentially solvable and can be remedied by modifications to the workplace.

Risk Factors:

<table>
<thead>
<tr>
<th>Content of Job</th>
<th>Organisation of work</th>
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<tr>
<td>• Overload of work</td>
<td>• Shift work</td>
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<td>• Deadlines</td>
<td>• Long working hours</td>
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<td>• Difficulty of work</td>
<td>• Unsociable working hours</td>
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<td>• Time pressures</td>
<td>• Unpredictable working hours</td>
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<td>• Under loading (work too easy)</td>
<td>• Restructuring</td>
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<td></td>
<td>• Non-consulted changes</td>
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<thead>
<tr>
<th>Workplace culture</th>
<th>Work role</th>
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<tr>
<td>• Communication</td>
<td>• Clarity of job</td>
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<tr>
<td>• Involvement in decision making</td>
<td>• Conflict of interests</td>
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<td>• Feedback</td>
<td>• Conflict of beliefs</td>
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<td>• Resources provided</td>
<td>•</td>
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<td>• Support</td>
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<table>
<thead>
<tr>
<th>Structure</th>
<th>Relationships</th>
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<tr>
<td>• Over-promotion (self / others)</td>
<td>• Communication</td>
</tr>
<tr>
<td>• Under-promotion (self / others)</td>
<td>• Harassment</td>
</tr>
<tr>
<td>• Redundancy threats</td>
<td>• Bullying</td>
</tr>
<tr>
<td>• Pay structure / inequalities</td>
<td>• Verbal abuse</td>
</tr>
<tr>
<td></td>
<td>• Physical abuse / intimidation</td>
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<tr>
<td>Environment</td>
<td>Home-work interface</td>
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<tr>
<td>---------------------------------</td>
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</tr>
<tr>
<td>• Noise</td>
<td>• Childcare issues</td>
</tr>
<tr>
<td>• Temperature</td>
<td>• Transport problems</td>
</tr>
<tr>
<td>• Lighting</td>
<td>• Commuting</td>
</tr>
<tr>
<td>• Space</td>
<td>• Relocation</td>
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<tr>
<td>• (Perceived) hazard exposure</td>
<td>• Housing issues</td>
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**Symptoms & Signs:**
Stress is mostly observable through behaviours exhibited by the sufferer, rather than any physical symptoms, (as most physical symptoms of stress are non-specific) including:

- Excessive smoking
- Rushing and hurrying
- Missing breaks and meals
- Taking work home
- No time for relaxation
- Aggression
- Irritation
- Obsessive thoughts
- Concentration problems
- Nervousness
- Anxiety
- Tiredness*
- Confidence problems
- Indecision
- Carelessness or recklessness
- Relationship difficulties
- Loss of sexual interest
- Appetite loss
- Excessive drinking Excessive eating
- Insomnia*
- Difficulty waking up
- Poor time keeping
- Headaches*
- Sweating*
- Nausea*
- Dizziness*
- Palpitations*
- Tremor*

* These symptoms in the list are often known as non-specific symptoms, and are often not directly related to the psychosocial hazard in question. There are many additional factors that can effect the presence and severity of such symptoms in stressed workers, including perceptions and beliefs about the management and / or the organisation; any media interest and influence; any investigation into the causes of the stress, or any interest shown by health experts, nurses or doctors. These influences upon symptomology can often heighten and exacerbate workers’ responses to potential hazards in the workplace, which can make the true nature of any relationship between psychosocial hazard and symptoms difficult to define.
Clinical features:
- Cardiovascular problems (direct physiological)
- Infections (direct physiological)
- Immuno-suppression (direct physiological)
- Mental Health problems; anxiety or depression (direct psychological)
- Back pain (direct psychological)
- Cancers associated with increased use of drink, tobacco and drugs (indirect physiological)
- Musculoskeletal problems (direct psychological)

Psychosocial Aspects of the Workplace

Occupational Stress
It must be remembered that stress is an individual response that people can have to certain situations – and there is no universal profile of what would constitute a stressful situation for everyone. Psychological stress can often occur in people when the demands placed upon them outweigh their ability to meet those demands. Stress can also arise when workers are under-utilized – boredom and lack of challenge can be just as harmful as high demands. Such an imbalance can happen in all spheres of life, not just the occupational, although workplaces are the most common arenas where individuals will meet high demands or boredom. The types of demands that can cause stress responses in workers can be either psychological, physical, or both. An added complication to this is that many individuals who are clearly not able to cope with the demands they are struggling to meet may actually be completely unaware of any problem, and may often be the last person to realise they are stressed. In addition to potential problems brought about by demands, a second important factor is that of how much control people have in meeting such demands. Many jobs may be highly demanding, but if employees have the resources and freedom to control how they meet such demands, then such jobs are seen as being rewarding and productive. Those jobs however where individuals have little freedom in deciding how to do their tasks and cope with the high demands they are faced with are often seen as being stressful and harmful. Jobs with little freedom or autonomy, and no control over how the worker chooses to perform his/her tasks, conducted in an environment where the worker may have little control over his/her surroundings (such as noise, lighting or temperature) would make for classic examples of stress-inducing work.

The Effects of Stress
It can be difficult to always confidently and clearly ascribe specific health problems to the presence of psychosocial hazards in individuals’ workplaces, although large-scale epidemiological evidence has demonstrated the contributory role of stress in the development of ill-health. The health effects of stress can be viewed as occurring on three distinct levels; psychological effects (such as worry, anxiety or depression), behavioural effects (drinking or smoking more, arguing with colleagues) and physical effects (cardiovascular problems, musculoskeletal problems, or accidents). It must be remembered that health effects attributed to stress can either be direct effects, such as decreases in cardiovascular well-being due to prolonged physiological changes in the stressed person, or indirect effects, such as lung cancer, exacerbated by the (behavioural) effects of smoking more while stressed.

The number and type of psychological or emotional symptoms exhibited by stressed individuals can vary greatly from person to person, as can the behaviours they may indulge in as a way of coping with any stress they may feel.
Managing Occupational Stress

Management of occupational stress is likely to be unsuccessful unless a clear understanding of what may be causing the stress is gained. Many organisations and workplaces conduct surveys and interviews with their employees to ascertain what the sources of stress could be, and what the workforce stress levels are. The most reliable and straightforward method of conducting a stress survey can be done by using anonymous postal questionnaires, and many stress assessment tools are available for off-the-peg use in most organisations. The best management of potential psychosocial problems in the workplace will contain all three of types of intervention that are described below.

Primary interventions
When sources of stress are identified which are potentially avoidable, they should always be reduced by a change within the organisation that will tackle the specific cause or source of stress. In addition, organisational measures can also reduce problems which may be intrinsic to the operations of concern to the organisation (e.g. in jobs with a threat of customer-to-employee violence, the introduction of call-back procedures and buddy –systems may help reduce employee stress).

Secondary interventions
When jobs are expected to be inherently stressful, such as emergency services or those which involve working with members of the public, it is often appropriate to train workers in specific stress management or avoidance techniques. Some training is designed to reduce the likelihood of stressful situations developing, or to help employees control such situations, such as aggression management or assertiveness skills, while other training can be aimed at minimising the effects of stress, such as personal stress management training or relaxation skills. Such training is useful, but is not a substitute for any primary intervention measures that could reasonably be taken.

Tertiary interventions
For those who have suffered stress and may go onto to exhibit severe effects, counselling services are appropriate, and this may also be appropriate for unusual or dangerous incidents that could result in Post Traumatic Stress Disorder for some individuals. Other non-occupational difficulties that may be affecting an individual’s work performance could also benefit from counselling, such as substance misuse or relationship difficulties.

Special Problems
Post-Traumatic Stress Disorder (PTSD)
Despite the histories of shell-shock and battle-fatigue, post-traumatic stress disorder was originally conceived by psychiatrists as a “political” diagnosis specific to military personnel returning from the Vietnam war, but in recent years, the diagnosis of PTSD has spread to be used more widely in non-military spheres. In some occupations, such as the emergency or uniformed services, individuals are more likely to be exposed to traumatic or disturbing events and incidents. However, in relatively more mundane occupations, where traumatic incidents are not routinely expected, the occurrence of such incidents can produce equally devastating effects for individuals. Some workers may, as a result of exposure to such events, suffer from this syndrome, which is a form of an extreme response to stress, characterised by the following diagnostic criteria:

- Experience of intense fear
- Persistent re-experience of fearful event
- Avoidance of associations with fearful event
- Persistent increased arousal
• Flashbacks to traumatic event
• Hyper-arousal – sleep and concentration problems; irritability

PTSD, as a recognised and diagnosable psychiatric condition can become chronic and disabling in individuals, and several types of intervention are worthwhile considering for such affected individuals, which can utilise cognitive, behavioural and pharmaceutical help:

Talking therapies
This would involve encouraging the sufferer (if willing or able) to talk through what has happened to them – either soon after the incident or after some time has elapsed, the timing of which is best dictated by the sufferer. Evidence for this can be mixed – it might work for those sufferers who want to talk about their experience, but not for those who do not.

Tackling avoidance issues
Tackling avoidance issues can be done by discussing and planning a gradual increase in activities with which the victim has problems e.g. slowly returning to road travel after a car crash, using graduated steps of exposure to road travel; again, the level of gradation is best dictated by the sufferer.

Coping with anxiety
Anxiety management techniques can be used to help the sufferer control his/her fears and stress levels, such as learning methods of relaxation, distraction techniques or self-hypnosis.

Dealing with anger
Dealing with anger is a cognitive technique aiming to encourage the sufferer to discuss feelings concerning what has happened, and to make sure the sufferer does not blame him/herself unduly.

Overcoming sleep problems
In order to overcome sleep problems the importance of regular sleep habits in coping with any distress should be emphasised, and the avoidance of excessive caffeine and alcohol use encouraged.

Treat associated depression
There may be a limited but crucial role for the use of anti-depressants, hypnotics, and anti-anxiety medication immediately after the traumatic incident.

Musculoskeletal Disorders
The translation of many psychological stressors into physical disorders is well documented, such as cardiovascular disease, and immunological disorders. A straightforward explanation of why occupational stress has an effect on the incidence of musculoskeletal disorders could be that it is the result of the extra physical demands placed upon a busy and stressed worker. In addition, it can be seen that the amount of work may correlate with the severity of musculoskeletal complaints. However, much research indicates this is too simplistic an explanation and that there are more complex mechanisms involved which link psychosocial hazards in the workplace with musculoskeletal problems. Some research has found musculoskeletal problems to be completely unrelated to the amount of physical exertion involved in a job, with such physical factors seemingly unimportant in comparison with the role psychosocial hazards play as predictors of musculoskeletal problems. Psychosocial hazards that have been linked with
increased musculoskeletal problems are monotonous work; perceived high work load; lack of control; lack of social support, and time pressures.

The Role of Personality
There are many different types of personality and character within individuals, and some of these personality types may make certain individuals more prone to some workplace problems than others.

Type A or Type B
In this form of behavioural assessment, most individuals can be categorized as either being of type A or type B personality. The type A behaviour style has been associated with individuals who may suffer more from occupational stress and from conditions such as severe fatigue and even cardiovascular problems. The type A behaviour pattern can be characterised by a high need for achievement and recognition, increased competitiveness, aggression, restlessness, and impatience. Type B individuals tend to be more calm and relaxed, and place a higher value on enjoying experiences rather than demonstrating their achievement. This could be why type B individuals are often more resilient to occupational stress and related problems, although nobody is truly sure why this is the case, and therefore it is best to say that a type B personality is merely associated with fewer of these problems.

External / Internal Locus of Control
Individuals with a highly developed internal locus of control are those people who have a strong belief in the influence of their own decisions upon their personal circumstances. An internal locus of control can be seen as a hallmark of those who see themselves as self-motivated and believe they do things for themselves. In contrast, those individuals who believe that their situations are determined largely by other people or by chance, and who have a tendency towards powerlessness in their lives, are seen as having an external locus of control. It is those individuals with an external locus of control who are often psychologically vulnerable when faced with highly stressful situations, while those with an internal locus of control tend to be generally more hardy and resilient.

Coping Mechanisms
The way individuals may cope (wittingly or unwittingly) with a stressful or traumatic occupational situation will often be determined by their personality type as well as by other intrinsic psychological factors. Some types of coping can be seen to be adaptive in that they are positive steps to confront any problem and to seek a genuine long-term solution. Other types of coping may be seen as maladaptive, in that the individual may try to cope by drinking, smoking, or eating more, or taking excessive sickness absence. Such maladaptive strategies can be seen as only offering temporary or short-term solutions to any problem, and may themselves result in further health problems. Stress management training and other forms of secondary intervention (as discussed earlier) tend to emphasize the use of adaptive strategies.

Psychological Assessment of Stress
There are many simple-to-complete stress assessments that almost any worker can complete by themselves. After simplicity, the two most important aspects of any stress assessment that an employee can compete are those of validity (in that the assessment actually measures stress and not something else e.g. perhaps a mental health problem) and reliability (that if the assessment were to be completed a number of times by the same person, the outcome measure / stress score should be essentially the similar). Results obtained from stress assessments can be very useful in understanding what various sources of stress may be for workers, but also in understanding what a sensible and effective solution would be. It is recommended that results of
stress assessments are not used in isolation, but used in combination with other information that can be indicative of stress, such as sickness absence patterns, productivity, or turnover. Some common examples of popular stress assessments are given below.

The General Health Questionnaire
The most common assessment of worker mental well-being still seems to be the General Health Questionnaire (Golberg, 1985), and although not a true measure of occupational stress, it is a measure of common mental health problems. Developed as a screening tool to detect those likely to have, or to be at risk of developing psychiatric disorder, it is available in a variety of self-completion versions, using either 12, 28, 30 or 60 questions. Each question item is accompanied by four possible responses, each one more symptomatic than the preceding one. A selection of some items from the GHQ is shown in table 1.

Table 1: Some items from the GHQ 28

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<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>No more than usual</th>
<th>Rather more than usual</th>
<th>Much more than usual</th>
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<tr>
<td>Been getting edgy and bad tempered?</td>
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<tr>
<td>Been getting scared or panicky for no good reason?</td>
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<tr>
<td>Found everything getting on top of you?</td>
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<tr>
<td>Been feeling nervous and strung-up all the time?</td>
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The likelihood of “psychiatric caseness” is determined by a threshold score value. The abridged 28-item version of the questionnaire is often selected in preference to any other version partly because of time considerations for respondents, but also because the GHQ28 has been used most widely as a measure of mental health in other working populations, allowing for more valid comparisons. As well as providing a global mental health score, the GHQ also provides four subscales: somatic symptoms, anxiety and insomnia, social dysfunction, and severe depression.

The Life Events Inventory
Now that you have completed the LEI yourself, you can recognise its role in stress assessment. The LEI is a checklist of potential stressful events, adapted from the original Schedule of Recent Experiences Checklist by Holmes and Rahe (1967) with subsequent modification and renaming as the Life Events Inventory by Cochrane and Robertson (1973), updated almost thirty years later by Spurgeon et al. (2001). The LEI checklist is a self-completion assessment for individuals to serially scan and to tick (true positive) if any listed event has occurred to them in the previous 6 months. Individuals then receive (i) a “severity rating”, based on the sum of the weights attached to each of those events that have been identified in the individual’s life (although the respondents are not shown the weightings when they complete the assessment), and (ii) an event frequency rating, based on the number of events the individual confirms have occurred in the previous 6 months. Weightings of the stressful events have been established separately for the sexes. An advantage of the LEI is that it focuses on potentially stressful events from both the domestic and occupational spheres, and does not limit the stress-assessment to solely occupational causes – which makes the LEI useful in gathering a stress-profile of the “whole worker”.