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Finnish Occupational Physicians' and Nurses' Experience of Work Related Stress Management: A Qualitative Study

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Abstract: Work-related stress has a strong influence on the health of workers. Occupational health care has an important role in assessing and managing this stress in collaboration with enterprises. The methods to reduce stress can be directed at the individual and at the organization as a whole. There is little information about stress handling methods in occupational health practices. This study aims to investigate these practices in Finnish occupational health physicians' and nurses' work. The data were generated through semi structured interviews of ten voluntary occupational physicians and eight occupational nurses in the metropolitan area of Finland in June 2009. The work-related stress was experienced as difficult to handle. There was no specific protocol for handling work-related stress in practice. Stress reduction activities were mostly randomly directed at the individual or the organizational level. Activities remained mainly on the individual level and were rarely allocated to the organization. There is a need for structured guidelines on how to manage work-related stress to assure standardized action on both the individual and organizational level. The roles of the physician, nurse and psychologist should be clarified in teamwork. Their collaborative activities should be directed also to the organisational level.

Key words: Clinical practice guidelines, Occupational health nursing, Occupational health physicians, Occupational health service, Practice management, Stress

Introduction

Work-related stress is a modern problem. In Europe, it has been noted as one of the most significant work-related risk factors to employees' poor health[1)]. Different working conditions, such as work overload, poor supervisory and social support, limited influence over decision-making, and disparity between work and individual resources, have been discovered to cause work related stress, when they last for long periods[2–6)].

Prolonged work stress has a negative effect on workers' health. An association between work-related stress and cardiovascular diseases, depression, and back pain has been noted in different studies[7–9)]. Although work-related stress is not a formal diagnosis, it increases the risk of sick leave, early retirement and use of antidepressants in the working population in all sectors of employment[10–13)].

Several intervention studies have examined how work stress could be handled. Most studies have been carried out at individual levels. In particular, cognitive behavioural therapy- interventions have proved effective[14–16)]. Recently, more studies have emerged on how to contain work stress at the organizational level. In addition, there is some evidence of the effectiveness of organisational interventions[15, 17–20)].

By improving the working conditions causing work-related stress, the stress in itself, as well as its consequences such as sickness absences, can be handled and controlled[11, 21)].

In Finland, physicians and nurses constitute the basic team in occupational health care. They consult occupa-

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tional psychologists as necessary. Occupational health services (OHS) undertake preventive actions, which include assessment of work risk factors, such as psychological risks. They also make proposals for attenuating the risks observed. Finnish OHS differs from the OHS in other European countries as it can also provide medical services for employees.

At the time of the interviews, in 2009, there were no national guidelines regarding work-related stress in Finland. Though some instructions and training in managing stress with cognitive behavioural methods at the individual level, no recommendations existed for the organizational level action[22].

Several studies have been carried out on different work-related stress factors and their influence on health and work ability, but few studies exist on the methods used by occupational health services to assess or manage work-related stress in practice. The aim of this qualitative study is to explore the methods used in Finnish occupational health care to address work related stress, from the perspective of the occupational physicians and nurses. The study was conducted in order to inform the development and implementation of a future Finnish work-related stress guideline. The topic of study is limited to work-related stress in employees without any major health problems, and does not include burnout, depression or other psychiatric symptoms.

Subjects and Methods

The data were collected and analysed in May-June 2009 by one interviewer. The participants were occupational physicians and nurses from a Finnish metropolitan area. Three male and seven female physicians participated. All of them had several years of experience in the occupational health care field and had worked in both private and public occupational health care sectors. Two of them were specialized physicians in occupational health care, and the rest were in the process of specializing in occupational health care. The eight occupational health care nurses interviewed were all female with working experience in private and public occupational health care services from one year to over 20 yr. The sample was chosen to reflect variation in age, gender, professional experience and workplace.

The interviews were individual, semi-structured, audio-taped, and each were approximately one hour in duration. All of the participants were informed of anonymity and their right to withdraw from the study at any point. Permission to tape-record the interviews and use material anonymously was asked separately from each participant. As the interviews were conducted in the workplace during working hours, permission to conduct interviews was obtained from the participants' supervisors in order to make it easier to participate.

The data were analysed using content analysis. The interviews were transcribed in full and read several times by the interviewer and then analysed to obtain an overview of the data. Themes and questions that emerged in early interviews were explored in subsequent interviews. The emerging themes were developed into categories using codes derived from analysis. They were compared and contrasted using the constant comparison method. Similar themes were combined in categories. The categories were again compared to each other and adjusted.

No approval from an ethical committee was needed because no patients were included in the study, and all the participants were voluntary (The National Advisory Broad on research Ethics 2002).

Results

The interviews aimed to identify what the term work-related stress meant to participants. Participants associated the concept of work-related stress with general strain, fatigue, exhaustion, burnout and other mental symptoms. Work factors causing stress were mentioned less often. Physicians felt that work-related stress was hidden behind different diagnoses such as pain or mental symptoms, because work-related stress does not qualify a patient for sick leave compensation in Finland. Work factors causing stress were more unfamiliar to nurses.

Handling work-related stress was seen as part of the responsibilities of OHS. The role of OHS was seen as being a general appraiser of the situation and an active participant in raising matters relating to work-related stress. Participants felt that the roles involving appraisals and actions should be more distinct for both occupational health care and enterprises, because most actions for modifying stress factors were seen as only possible to be made by enterprises.

None of the participants had worked in occupational health care units where written, agreed standardized procedure for assessing or handling work-related stress existed. The actions done to address work-related stress varied according to practitioners, patients and situations, and were done at both the individual and the organizational level. In general, work-related stress was experienced as difficult to handle and participants considered their own skills for handling work-related stress scanty.

At the individual level, clients were not actively asked about work-related stress during health examinations and there was no systematic or commonly agreed

assessment method in use. Usually the issue of work-related stress was only raised when a single employee contacted the OHS. In these cases, the situation was assessed more closely using non-structured interviews, in order to clarify the situation. Some OHS used the Berger Burnout Indicator 15 (BBI-15) or a depression questionnaire to evaluate burnout[23, 24].

The main problem in addressing work-related stress was seen by participants as not having equipment or a clear assessment method measuring work-related stress with clear limits to actions. The behaviour of other occupational groups, skills' in interpreting results and the cost of assessment to enterprises were seen as barriers to the unification of the assessment practice.

Psychosocial factors were rarely assessed at the organisational level, it was mainly assessed through non-structured interviews with employees during workplace visits. The 'TIKKA' workload appraisal, developed by the Finnish Institute of Occupational Health, was rarely used for the assessment of the work environment. This evaluation tool was developed to help occupational professionals analyse mental well-being, identify factors promoting mental health and working conditions that are protective or preventive factors in relation to mental health during workplace visits[25].

After work-related stress was assessed at the workplace, interventions at the organizational level were rare. Action at the organisational level was only taken into consideration if there was more than one stressed person at one workplace. There was no agreed upon procedures on addressing stress and actions were case-specific and depended on the participants' own experience.

The basic occupational team of physician and nurse felt that they treated only single individuals, listening and supporting them, and that they did not act at the organizational level. Their own expertise in handling organizational level stress was assessed as limited and there was a need for additional training. Stress management at the individual level was usually allocated to occupational psychologists in the occupational team if the contract with the enterprise allowed this. Occupational psychologists were considered to have more preparedness and more time, also for organizational interventions. Occupational physicians were generally interested in information on work-related stress, but they felt that they are not therapists and that this should not be part of their work. They considered it sufficient to have a psychologist as an expert in the team. Actions related to work stress were irregularly followed up.

Participants thought that workplaces had no protocol for when, how, or who to contact in cases of work-related stress. Communication with the enterprise regarding work-related stress was considered difficult, because legislation created limits and restrictions to communication between workplaces and OHS's regarding the health-related information of an individual person[26]. The permission of the stressed person was needed in order to collaborate with the workplace.

Participants saw the organization as responsible for developing solutions for work-related stress. However, participants did not know how to transfer the responsibility for managing stress the organization. The most difficult aspect was getting enterprises to understand and commit to the recommendations made by OHS.

Although some physicians were worried that stress management protocols might medicalize stress, most participants were in favour of a standardized guideline. They felt that work-related stress management protocols should be jointly created by OH and the enterprise, as this would help collaboration, commitment and communication in future interactions. Participants felt that clear protocols and clear role differentiation, with concrete action proposals, were needed.

Discussion

This study evaluated the practices of work-related stress management in Finland from the perspective of occupational nurses and physicians and provided an understanding of actions in practice. At the time of the study, there was no national guideline regarding work-related stress.

The stress is a common term in everyday use. In the OHS it was associated with mental symptoms and not seen as a disease in itself.

Several factors influence work-related stress management in OHS context. The attitudes and knowledge of nurses and physicians in OHS and the attitudes of employers are important. Work-related stress is considered difficult to handle and participants suspected they did not have sufficient skills in managing work-related stress. Lack of knowledge on how to deal with work-related stress can influence the willingness to intervene. There was a lack of information on how to intervene in work-related stress at the organisational level. The opportunities to influence working conditions were considered limited and the enterprises were perceived as having responsibility for changing working conditions. The enterprises' willingness and skills to intervene in work-related stress was sometimes suspected. There were no agreed upon ways of co-operation between OHS and enterprises with regard to work-related stress and no role descriptions. Therefore the need for practical methods and advice on intervening in work-related stress was seen as significant.

Actions taken to handle work-related stress by OHS varied according to their skills to act and availability of practical protocols. It was also influenced by the will of a single patient in OHS and the willingness of the enterprise to act, the contracts between the OHS and the enterprise and how the OHS organised teamwork.

The main action taken by OHS regarding work-related stress was individual support after an interview assessment, if the patient brought up the issue. Roles of each team member in handling stress were not defined. The responsibility for managing work-related stress was mostly transferred to OHS psychologists.

The cognitive behavioural therapy has been seen as the most effective method to handle work-stress in several studies. It has been, however, carried out by a psychologist or a trained therapist and not usually by occupational physicians or nurses[14–16]. The Dutch national guideline regarding OPs' management of employees with mental health problems included short cognitive therapy as a method to handle stress on an individual level. However, the adherence of Dutch occupational physicians' to the guidelines has been poor, despite its acceptance in principle[14, 16, 27]. The demand for physicians and nurses having therapy skills is in contrast with the results of this study. The general opinion was that neither occupational physicians nor occupational health nurses are therapists. In their view, therapeutic skills belong to occupational psychologists, though not every OHS team in Finland has a psychologist available to them. Nurses or physicians are not often able to give specific stress handling therapy. In general, this was also not seen as one of the tasks of occupational physicians and nurses. In this study, the normal counselling methods for stress management done at the individual level were seen as scarce by participants. Therefore the roles and tasks in OHS should be defined, according to the resources available.

The study has some limitations that may weaken the credibility of the findings. The participants may not be representative of all occupational physicians and nurses in Finland because they worked in a metropolitan area and this may influence their opportunities to participate in work-related stress method training. Participants' willingness to participate might also influence the results as those who did not want to participate might have had different opinions. The participants were chosen according their interest and experience in the research topic, because random sampling would not necessarily provide the required information. Another limitation of the study was the small number of participants. There are several opinions on the number of participants in qualitative studies, but no consensus on the lowest possible sample size. The small number of participants in this study was not considered problematic, as the participants represented all age groups and had working experience relevant to the research topic[28, 29]. One of the limitations of this study was that the occupational nurses were all women. Health and social service staff in Finland is very female-dominated. The proportion of men in 2008 was high 11%[30]. Because of this high rate of women in field, the relatively few male opinions was not considered problematic.

Information regarding stress handling methods exists on the individual level, but similar information is lacking on organizational level[15]. Most activities are focused on people already under stress and preventive actions have not been explored widely. Therefore, their effectiveness is not yet known. Research regarding harmful working conditions causing work-related stress already exists. By influencing these areas, work-related stress can be influenced at least on a theoretical level[11, 14, 19–21]. Research can perhaps show the effectiveness of interventions on influencing risk factors for work stress.

This study has revealed a number of obstacles to intervening in work-related stress. Methods for managing work-related stress are not well known. The participants' own attitudes and skills towards work-related stress seemed to influence most the actions in practice. It is challenging to find ways to intervene in this situation. The role of OH in work-related stress handling in client enterprises should be elaborated in more detail. Future studies should be focused on interventions conducted by OH in collaboration with enterprises that are directed at the organizational level.

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