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A Review of Occupational Stress Management Techniques and Interventions at Workplace

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ABSTRACT

In this paper, the author reviewed the empirical researches into occupational stress interventions conducted in India within the past 10 years. They studied the evidence published and the quality of the evidence base. All intervention studies were conducted in the public sector. Only 1 study reached the gold standard in evidence-based research. Most interventions were individually focused, despite the preponderance of research identifying risky work environment stressors. Review Results suggest a paucity of published information regarding what works with occupational stress interventions in India and an urgent need for further research in the area, particularly focusing on the private sector, rural workers, and scientific evaluation.

Key Words: work stress; stress research; public sector programs; work stress interventions; prevention.

1. INTRODUCTION

The impact of stress in the workplace is well recognized, with both human and financial costs investigated in the literature. In India, employees are entitled to workers' compensation for stress when the claimant's employment significantly contributes to stress; this does not include situations in which reasonable disciplinary action or failure to obtain a promotion, transfer, or other benefit in relation to employment occurred. Most states in India report an increasing number of stress claims per annum, and although the percentage relative to all other claims is low, the cost per claim is generally much higher, as is the time absent from work.

Various reasons have been posited for the increasing rates of claims in relation to workplace stress in India. As Dollard and Wine field (2006) suggested, under the pressure of economic rationalism, workforce numbers have been reduced even though the amount of work to be done has not. As a consequence, many workers in full-time jobs are experiencing over employment, resulting in job intensification, increased work pressures, and longer hours, all of which may result in increased levels of work stress. Indeed, the Work Cover Corporation of South India (2009) reported that workload pressures account for 37% of work-related stress claims, and almost half of the claim costs, in this area. Even jobs that were once considered relatively stress free, such as university teaching, are becoming increasingly stressful.

In addition, there has been a decrease in the number of full-time jobs and an increase in part-time, casual, and contract labor. Organizational downsizing has resulted in reduced job security and stability for many people. A rapidly changing workplace through globalization and technological advances has caused the nature of work to become more fluid, with many workers expected to learn new skills, perform multiple tasks, and self-manage (Kendall et al., 2005). This in turn has led to increases in role ambiguity, possibly resulting in increased work stress and illness (Dinette, 2008). The financial costs of work-related stress reported by organizations such as the National Occupational Health and Safety Commission are likely to be quite conservative given the loss in productivity, staff turnover, absenteeism, and industrial accidents and the additional costs associated with return-to-work programs or redeployment, which are not accounted for in these financial estimates.

Also, the stigma associated with making a compensation claim on the basis of intangible causes, such as occupational stress, could mean that the real incidence of stress in the workplace is much greater than the statistics suggest (see Dollard et al., 2006). In all likelihood, only the most serious stress cases will result in the lodging of a worker's compensation claim; workers who make claims may do so as a last resort, often after all other leave entitlements have been taken. The problems associated with work-related stress surpass financial considerations. The human costs in individual suffering and organizational morale cannot be reduced to quantitative terms. The stress of overwork has been associated with psychological problems such as depression,

anxiety, and burnout; physiological health problems, such as hypertension and heart attacks; and organizational problems, including workplace violence and accidents. Workplace stress may also result in behavioral problems, such as increased alcohol consumption and smoking (Dollard & Winefield, 2008).

Work stress appears to have multiple origins, and much of the reported research attempts to establish links among taxing aspects of the work environment (stressors); perceptions and appraisals of these; and manifestations of strain, including physiological, psychological, and behavioral changes (Baker; Greenhaus & Parasuraman). A number of theories have been developed to conceptualize the problem of occupational stress and to explain and predict when work stress will occur (Dollard, 2001b). Some of these theories concentrate on the stressors within the work environment (e.g., the demand–control/support model; Karasek & Theorell, 2007), some focus on the mismatch between organizational requirements and rewards (e.g., Siegrist's effort–reward imbalance model), some have a greater focus on the resources available to employees to cope with demands (e.g., the conservation-of-resources model; Hobfoll & Freedy), and others focus on appraisal and coping to explain individual differences in reactions to stress at work (e.g., Lazarus and Folkman's [2009] cognitive phenomenological theory).

Although all of these models have received some empirical support in the literature, the dominant view is that work stress and the resulting mental health outcomes are more strongly related to job factors or aspects of the work environment rather than to personal or biographical factors that is, work stress depends primarily on the way that jobs are constructed, constituted, and managed (Dollard & Winefield, 2007).

De Jonge and Dollard (2012) presented a matrix of stress management approaches (see Table 1) that focus on the three levels of prevention (i.e., primary, secondary, and tertiary) and possible intervention strategies within each level, emphasizing the individual, the organization, or the individual.

Table 1: Overview of Work Stress Interventions

Level	Primary prevention	Secondary prevention	Tertiary prevention
Organization	Improving work content, fitness programs, career development	Improving communication and decision making, conflict management	Vocational rehabilitation, outplacement
Individual–organization interface (e.g., team or group)	Time management, improving interpersonal skills, work/home balance	Peer support groups, coaching, career planning	Posttraumatic stress assistance programs, group psychotherapy
Individual	Preemployment medical examination, didactic stress management	Cognitive–behavioral techniques, relaxation	Rehabilitation after sick leave, disability management, case management, individual psychotherapy

2. METHODOLOGY

In Stage 1, we conducted a literature review using the EBSCO Host search engine. We used the limit options to narrow the search for articles that had been published in the last 10 years (i.e., since 2005).

In Stage 2, we selected only those articles in which an empirical study with an intervention had been conducted with Indian participants. In Stage 3, we assessed the intervention studies on a range of criteria.

Review Procedure

Two reviewers independently reviewed the articles and then agreed on a descriptive framework to review the studies. Then, each reviewer independently assessed the articles against the descriptive frameworks. All studies

were first assessed for scope of inquiry in the following areas: Industry: the type of work examined in the research and whether this work was situated in a public or private sector context Location: urban, rural, regional Stressors: whether the focus of the research was on aspects of the work environment, resources, or individual differences Strains: the stress experience of participants (e.g., psychological, interpersonal, physical) and the measures used Participants: the type of participants recruited for the research (e.g., nurses) Interventions: whether an intervention was implemented/evaluated The reviews were checked for interrater agreement, and a consensus of ratings was reached through discussion. The interrater agreement was 95%. We reviewed the intervention studies using the descriptive framework of Kompier and Cooper (based on Murphy, 2006):

Preparation: motives for conducting research, how the research was organized Problem analysis: instruments used, risk factors, risk groups Choice of measures: work directed or person directed Implementation: how the intervention was introduced in the workplace Evaluation: objective effects, subjective effects, costs and benefits, obstructing and stimulating factors, timing of follow-up As part of this framework, we assigned the research design of each intervention study a rating according to the following criteria (Kompier & Cooper, 2015):

3. RESULTS AND DISCUSSION

Summary of results for intervention studies conducted between 2005 and 2016 using Indian participants. Of the six intervention studies, only one was given a five-star rating (Craig & Hancock, 2006). The study by Leonard and Alison 2009) was given a four-star rating because although it was a well-conducted study with a control group, it lacked randomization. The remaining four intervention studies were all given a three-star rating. From the current review it is apparent that interventions have been primarily individually focused rather than organizationally focused. Only one intervention study was organizationally focused, compared with five that were individually focused. This is similar to results of other reviews, such as the one conducted by Van der Klink, Blonk, Schene, and van Dijk (2013), who found that organizationally focused interventions were implemented in only 5 out of 48 studies.

The United Kingdom review study conducted by Giga et al. (2013), who used search parameters similar to those used in this study, found that, of all post-1990 studies reviewed that received a three-star rating or higher, only 19% were organization-level interventions. Such results are consistent with Kompier, Cooper, and Geurts's (2014) suggestion that work stress programs are predominantly reactive (i.e., secondary or tertiary approaches) and tailored to the individual. Kahn and Byosiere (2012) put it another way, suggesting that attempts to reduce workplace stress are generally Band-Aid approaches that focus on reducing the effect of stressors rather than lessening the occurrence of these stressors in the first place. From the reviewed studies it appears that, overall, individually focused interventions do not seem to perform particularly well at lowering work stress. For example, Craig and Hancock (2016) aimed to teach university staff skills to self-manage stress through the implementation of a healthy lifestyle program involving relaxation techniques and biofeedback mechanisms.

The results of this study indicated no effect of these stress management skills in reducing the participants' physical or psychological ill health. These findings are supported by the research of Giga et al. (2013), who found that although individual-level interventions had some immediate benefits, the effects were less likely to be long term. Likewise, Walters, Bond, and Pointer (2015) examined the implications of providing an inservice education program to a group of nurses, teaching coping strategies to deal with workplace stressors (e.g., relaxing mental exercises). The findings indicated a reduction in stress symptoms, such as lowered blood pressure, although no reduction in self-reported stress. Thus, the nurses in this study continued to experience stress in the workplace, although they were better able to manage some of their symptoms. On a more positive note, the study by Wine field and Farmer (2013) examined the outcome of providing a program of stress management seminars to a group of female general practitioners. They found a decrease in the level of psychological distress and emotional exhaustion following the seminars.

The results of these individually focused intervention studies indicate that voluntary health programs aimed at teaching skills in stress management are not particularly successful in reducing the experience of workplace stress. On the other hand, seminar-based programs appear to procure better outcomes. However, these conclusions are made on the basis of only six intervention studies. There is an urgent need for more Indian intervention studies so that more valid conclusions can be drawn. The results of the organization-focused intervention reported by Dollard, Forgan, and Winefield (2013) were more positive than the individual focused interventions. Dollard et al. (2014) examined a sample of correctional officers and found that improving working conditions through job redesign, monitoring psychological disorders and risk factors, and improving psychological health services resulted in positive outcomes. These included a significant reduction in the number of work stress claims, reduction in expenditures on the worker's compensation budget, and increased utilization of the staff counselor. However, the authors pointed out that these findings could well be due to

government policy changes implemented during the observation period, which made it harder for workers to receive compensation, thereby reducing the overall expenditure.

It is interesting that all of the six intervention studies were from the public sector. The participants most regularly included in the studies reviewed were police officers, public service workers, and nurses. Furthermore, a large proportion of the research incorporated workers from the health services more often than from other occupational fields. This may represent a greater concern within the public sector regarding the work stress experience, it may be a question of greater resource availability within the public sector to implement stress management programs, or it may perhaps reflect a greater likelihood of the public sector to publish results. The preponderance of focus on "stress in the public sector" in the media and in the literature has been previously highlighted (Lewig & Dollard, 2015). There is an obvious need for research and for the implementation and evaluation of intervention programs in the private sector as well (Macklin & Dollard, 2004).

The results indicate a paucity of research studies conducted in rural settings. Rural India is considered to be different from the urban sector in terms of health and well-being (Dollard, Winefield, & Winefield, 2011). With higher unemployment rates, a lack of mental health resources (Blank, Fox, Hargrove, & Turner, 2015), and higher turnover rates for professionals (Harvey & Hodgson, 2015), it is possible that differences exist in the stress experience of rural versus metropolitan workers. A greater emphasis on the private sector, as well as a more concerted effort to include rural India, would add to the knowledge base highlighting any differences between populations and informing best practice for intervention in these target populations.

CONCLUSION

The high cost of stress-related workers' compensation claims highlights the need to spend more time evaluating work stress interventions and publishing the findings so that other organizations can gain insight into programs of merit. As Kompier et al. suggested, there exists at present a large gap between theory and practice. Without further research, our knowledge of what works with regard to occupational stress will remain stunted. Questions surrounding the issue of whether stress prevention actually works; which interventions are most effective, and why; and the costs and limitations of various interventions need to be explored further. Future work in this area should focus on uncovering Indian intervention studies or programs that have not been published and delving into the gray area of work stress interventions to find out what industry is actually doing to tackle the work stress situation.

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