

Stress at Work

the work foundation



A report prepared for The Work Foundation's Principal Partners

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Introduction

Stress is everywhere, but as a relatively new phenomenon. How can we define it and how can we explain its extraordinary cost to both business and government? The suffering induced by stress is no figment of the imagination but can we accurately examine the relationship between stress and ill-health?

Whatever stress is, it has grown immensely in recent years, which brings us to question – what is happening in society that is causing stress? The report shows that stress has its greatest effects on those at the very top and those at the very bottom of the socio-economic ladder.

The report considers recent analysis of stress and reviews a series of recent high-profile contributions to the debate. It then explores the legal and policy contexts against which organisations must operate in regard to stress. Finally, practical interventions are examined and critically evaluated.

What is stress?

Whilst it is arguable that the term 'stress' is so ubiquitous that it has been entirely cut adrift from both professional discourse and real life experience, it still retains a profoundly serious currency. Real or imagined, misunderstood or misused, rare or widespread, the problem of stress cannot be ignored.

Defining stress - The wider the usage of the term 'stress', the more elusive its meaning. Modern definitions of stress all recognise that it is a personal experience caused by pressure or demands on an individual, and impacts upon the individual's ability to cope or rather, his/her perception of that ability.

Work-related stress occurs when there is a mismatch between the demands of the job and the resources and capabilities of the individual worker to meet those demands. Subjective and self-reported evaluations of stress are just as valid as 'objective' data, such as statistics on accidents or absenteeism.

A recent report by the *National Association of Mental Health* distinguishes between stress and pressure, where pressure can be defined as a subjective feeling of tension or arousal that is triggered by a potentially stressful situation. However, where pressure exceeds an individual's ability to cope, the result is stress.

Explaining stress - The HSE has identified six categories of substantive factors that can be identified as potential causes of work-related stress:

- demands
- control
- relationships
- change
- role
- support.

Another potential risk factor is work-life balance. A 'vicious cycle' can occur when mounting stress in one area of life spills over and makes coping with the other yet more difficult. Palmer et al developed a model of work-related stress that helped to inform the HSE approach. This added a seventh driver of stress – culture – which is defined as 'the culture of the organisation and how it approaches and manages work-related stress when it arises'.

Stress and ill-health - There are clear links between work-related stress and a variety of physical and mental disorders, despite the difficulty of proving a direct causal link since the majority of diseases and syndromes commonly attributed to stress have multiple causes. The effects of work-related stress on ill-health operate in physiological, cognitive, emotional and behavioural ways.

The word 'stress' now forms part of most people's daily vocabulary but its reach and meaning remain unclear. Whilst the report starts off by providing a series of working definitions around stress, and charting its changing meanings, it goes on to look at more

quantitative evidence in order to shed light on the divergence between popular discourses and a more robust, evidence-driven understanding of stress.

An epidemic of stress?

How prevalent really is work-related stress in the UK? What differences are there in the prevalence of stress across a range of demographic variables, the type of job and industrial sector? What are the main drivers of work-related stress in the UK?

- **The extent of stress** - According to the Health and Safety Executive, in 2005:
 - more than 500,000 people in the UK believed they were experiencing work-related stress at a level that was making them ill
 - 245,000 people first became aware of work-related stress, depression or anxiety in the previous 12 months
 - 15% of all working individuals thought their job was very or extremely stressful, a slight reduction on the previous year
 - stress remains the primary hazard of concern for workers. However, levels of such concern have fallen significantly since 1998.
- **The costs of stress** - Estimates of the total cost of stress and stress-related illness vary enormously, largely due to the different methodologies used to arrive at a final figure but:
 - self-reported work-related stress, depression or anxiety account for an estimated 12.8 million reported lost working days per year in Britain (HSE)
 - after musculoskeletal disorders, stress is by far the largest contributor to the overall number of days lost as a result of work-related ill-health in the UK
 - stress is, on average, the costliest of all work-related illnesses in terms of days lost per case.

- **The victims of stress** - Statistics show that:
 - the majority of cases of work-related mental-ill-health occur in those aged 35-44 and 45-54 years
 - there is a noticeable difference in the difference in distribution of cases amongst men and women, with more cases amongst women in the 25-34 years age group, and more cases amongst men in the 35-44 years age group
 - full-time employment is associated with greater levels of stress than part-time employment
 - public sector workers are 64% likely to report stress to be the leading hazard of concern at work compared to 48% of workers in the private sector
 - stress levels rise in line with higher levels of educational attainment
 - stress is 29.1% more prevalent amongst black and minority ethnic workers than white workers
 - nursing, teaching, administrators in government and related organisations and healthcare are amongst the most 'stressful' occupations.
- **The causes of stress** -
 - Workload is the most pervasive factor linked to work-related stress.
 - There is little change in the relative importance of any of the factors linked to work-related stress since 2000.
 - Factors other than workloads include cuts in staff, change, long hours, bullying, shift work and sex or racial harassment.

Popular perceptions of a stress epidemic amongst UK workers are probably accurate, based on the sheer ubiquity of stress-related ill-health. Furthermore, levels of stress amongst UK workers peaked in the late 1990s and early 2000s and have stabilised since, even if at a high level. The particular industrial sectors, occupations and demographic variables give rise to an uneven distribution of work-related stress within the population as a whole.

Why now? What, in contemporary life, might be responsible for the sudden increase in the visibility of stress?

Stress, work and contemporary life

Whilst there are many events in the workplace that can be seen to contribute to stress, this is not the sole cause.

The development and increase of stress can be related to certain historical events and economic factors, with little meaningful significance but much rhetorical power. An increase in illness attributed to stress may be due to a raised awareness of stress which has only taken place recently, suggesting that stress is a reflection of historical context or even of current political ideology. People do, however perceive themselves to be under increasing levels of stress, particularly in the workplace, and these people are predominantly high status workers and low status workers.

Stress has become strongly linked to discursive constructions of identity and value. Clearly forms of insecurity do change over time, as do the conceptual languages we use to articulate their effects. Stress is such a language and its emergence and growing use both *makes* and *discovers* its object. Whether real or imagined, stress feels real, can be measured and is a significant cause of unhappiness.

Stress and happiness

Is the promotion of the greatest happiness for the greatest number the ultimate goal of both the individual and society? Richard Layard examines the link between stress and happiness, where human happiness is both objective and quantifiable, thanks to recent developments in psychology and neuroscience. He uses this to provide empirical evidence to demonstrate that increased wealth and prosperity do not necessarily make for happier citizens, even though people living in rich nations do tend to be happier than those living in poor ones.

So what does make us happy? Layard identifies the 'Big Seven' factors that affect happiness, with work being the most significant, since in addition to providing income, it is work which brings added meaning to life, creating self-respect and other social relationships. However, the reverse is also true: work can generate stress and unhappiness, which can be attributed to our inherent desire for social status.

Will taming the stressful 'rat race' and reducing social inequalities to restore a healthier work-life balance solve the problem? Layard certainly seems to think so.

Stress and social status

Social standing affects our health and longevity. Michael Marmot examines how and why this is the case and seeks to identify the ways in which we can alleviate social disparities in order to improve public health. In *Status Syndrome*, Marmot looks at stress in a different way, associating increased stress with the lack of agency/control that goes with positions of lower status. This runs counter to the more common perception of stress increasing according to how busy a person is, more often attributable to those in high status positions of social/occupational importance.

However, more recently, public and academic understandings of stress have been animated by more sceptical investigations.

The sceptics

Are stress levels really rising? Is it actually possible to measure stress? Are the political and cultural implications really accurate?

Some clear problems of method and management in relation to stress have been identified:

1. The self-reporting method of data-collection for stress raises questions about the reliability of the data due to its subjectivity.

2. Differentiating between stress that is work-related and that which is related to non-work factors is important but problematic.
3. Traditional methods of assessing risk and physical hazards cause problems when applied to stress.
4. Data on stress is often over-reliant on a single measurement, most often self-reported incidents and experiences.
5. The rise in the 'popularity' of stress is driven in part by cultural change.
6. Confusion over the meaning of stress has hampered advances in treatment and management.

Others argue that there is a growing domination of a therapeutic culture in Anglo-American societies promoting a conception of the human subject as weak, fragile and incapable of dealing with the emotions new experiences generate without medical intervention. Furedi, a cultural sociologist, would argue so, aligning his attack on therapy culture with a 'politics of happiness' which is being increasingly adopted by politicians from both sides of the spectrum. The consequences of governments and policy makers adopting the role of therapists who endeavour to heal society and manage emotions are potentially devastating to the democratic vision of social contract, in which autonomous and rational citizens hold their government to account.

Legal and policy contexts

Social and political debates notwithstanding, the problem of stress in the workplace requires concrete responses from employers and policy makers. The report examines the current legal context for stress before going on to look at how stress has been dealt with in public policy. Although the context in both cases is changing, there is clearly a growing responsibility for employers to contribute to the prevention and management of stress in the workplace.

Interventions

- **What does the evidence say?** - An analysis of the primary, secondary and tertiary strategies for stress management is provided, highlighting the many different methods of workplace intervention and using numerous examples and case studies as evidence.
- **Focussing on prevention** - It seems that in practice stress intervention strategies have tended to focus mainly on secondary and tertiary management techniques, namely minimising the impact of stress and identifying and treating its ill-effects respectively. These have failed to take action to reduce the presence of stressors in the working environment. The report therefore offers different models to help prevent stress and examines the suitability of current models in relation to the workplace stress, as well as other approaches to tackling the issue.

There remain widespread concerns about the precise nature of stress and what it says about contemporary society and workplace practices. As a word, stress has a dubious yet undeniable meaning; as a problem, stress is extraordinarily widespread, verging on epidemic proportions.

Stress continues to demand attention, with workplace stress becoming more and more costly, but solutions that ignore the very personal effects of stress and its manifestation, are likely to yield few results. Organisations concerned about the stress levels of their employees will need to focus greater attention on those issues within the workplace that are most likely to generate stress, self-reported or otherwise, and to work directly with the most vulnerable employees.

'Majority of NHS employers see staff suffering from stress'
Personnel Today, 2 November 2005

'Stress keeps more than 1,000 police officers a day off work'
Personnel Today, 18 January 2006

'Worldwide stress increase for business leaders'
Personnel Today, 17 February 2006

'Co-workers are employees' major source of stress'
Personnel Today, 27 March 2006

Stress, it seems, is everywhere - across the language of our everyday lives, in scientific and social scientific inquiry and as an increasingly important focus within a diverse range of policy environments. It is a relatively new phenomenon, is hard to define and explain and is extraordinarily costly. Each year, work-related stress results in the loss of nearly 13 million working days at a cost to UK employers of anything up to £12 billion.¹

Work-related stress is a topic of active research, and is the subject of ongoing practical initiatives. Yet, it continues to present significant difficulties. These include how to determine its true nature, how to prevent its increase and how it is most effectively managed. Advances are evident in a number of both theoretical and practical fields and it is these that are surveyed and evaluated in the research report which follows.

The first difficulty considered here is that of definition. Stress is variously defined and is attributed to a still greater variety of causes. Nor is it by any means clear that stress is something real. Could it not also be explained by the pampered weakness of modern man? A review of available explanations shows that stress can be as much a reflection of culture and personality as it can objective fact. Yet

¹ Health and Safety Executive and Confederation of British Industry. For detailed analysis of the costs associated with work-related stress, see Section 2.2

this, in turn, points to a second difficulty: the precise nature of the relationship between stress and ill-health. The suffering induced by stress, however, is no figment. Nor are its financial costs to both business and government merely imaginary.

As we shall see, *whatever* it is, stress has grown rapidly in recent years. It is therefore of some importance whether or not there is an epidemic of stress, what is causing it and whether it will continue to rise. Attention then shifts to the question of why stress is occurring now. What is happening in society, contemporary life and current working practices that is causing stress? There is much troubling evidence that we are more stressed and less happy than we used to be. Yet there is more evidence still that our experience of stress relates strongly to issues of social status, and relative social status at that. As we shall see, stress has its greatest effects upon those at the very top and those at the very bottom of the socio-economic ladder.

Concerns over how stress is to be studied and measured become daily more pressing, and the report considers recent analysis of such questions in some detail. It also examines a series of recent high-profile contributions to the debate. The report then explores the legal and policy contexts against which organisations must operate in regard to stress. Finally, and most importantly, practical interventions are reviewed and critically evaluated.

1. What is stress?

The continuous and frequently heated debates about how to define stress are a measure of how much it now permeates everyday language. In the course of a given day, each of us will hear or use the word in a variety of contexts. It is variously, a term of derision or one of abuse; it may be used to dismiss or critique colleagues or alternatively, to validate a 'high-octane' style of working. The term attaches itself to feelings of pressure, anticipation or even dread; as in meeting deadlines or watching one's football team participate in a penalty shootout. It is arguable that the term is now so ubiquitous that it has been entirely cut adrift from both professional discourse and real life experience.

However, the term retains a profoundly serious currency. It is used to describe genuine suffering, either as a result of daily pressures, or momentous events. In other words, there may well be something lurking in the woods that most of us will chance upon at some point in our lives. Real or imagined, misunderstood or misused, rare or widespread, the problem of stress cannot be ignored. Certainly, as this section demonstrates, stress continues to be a topic for critical research.

1.1 Defining stress

Organisations vary in their operational definitions of stress and this in turn produces the differing responses and contractual arrangements used to address it. Social scientific researchers are no more unified in their definitional approaches. Indeed, it would seem that the wider its usage, the more elusive its meaning. Pollock has argued that the term has now become 'so vacuous that it represents an obstacle rather than an aid to research, and that further investigation of the relationships which the stress theory attempts to elucidate would get on better without it.'² There are, however, a number of working definitions which suggest the word still has some meaning.

² Pollock K, 'On the nature of social stress: production of a modern mythology', *Social Science and Medicine*, Vol. 26 No. 3, 1988

Box 1: Definitions of stress

Modern definitions of stress share a number of essential ingredients. They all, to a greater or lesser extent, recognize that stress:

- is a personal experience
- is caused by pressure or demands
- impacts upon the individual's ability to cope or, at least, his/her perception of that ability

'Stress arises when individuals perceive that they cannot adequately cope with the demands being made on them or with threats to their well-being'

Lazarus, *Psychological Stress and the Coping Process*, 1966

'Stress ... can only be sensibly defined as a perceptual phenomenon arising from a comparison between the demand on the person and his or her ability to cope. An imbalance in this mechanism, when coping is important, gives rise to the experience of stress, and to the stress response'

Cox, *Stress*, 1978

'Stress results from an imbalance between demands and resources'

Lazarus & Folkman, *Stress, Appraisal and Coping*, 1984

'Stress is the psychological, physiological and behavioural response by an individual when they perceive a lack of equilibrium between the demands placed upon them and their ability to meet those demands, which, over a period of time, leads to ill-health'

Palmer, 'Occupational Stress', 1989

'Stress occurs when perceived pressure exceeds your ability to cope'

Cooper & Palmer, *Conquer Your Stress*, 2000

'[Stress is] the reaction people have to excessive pressures or other types of demand placed upon them. It arises when they worry that they cannot cope'

Health and Safety Executive, Raymond 2000, 'Stress the Real millennium Bug'

'Stress occurs where demands made on individuals do not match the resources available or meet the individual's needs and motivation... stress will be the result if the workload is too large for the number of workers and time available. Equally, a boring or repetitive task which does not use the potential skills and experience of some individuals will cause them stress.'

Trades Union Congress, Raymond 2000, 'Stress the Real millennium Bug'

'That which arises when the pressures placed upon an individual exceed the perceived capacity of that individual to cope'

Confederation of British Industry, Raymond 2000, 'Stress the Real millennium Bug'

'The emotional, cognitive, behavioural and physiological reaction to aversive and noxious aspects of work, work environments and work organisations. It is a state characterised by high levels of arousal and distress and often by feelings of not coping.'

European Commission, DG, *Guidance on work-related stress*: 1999

Work-related stress

The Health and Safety Executive (HSE) defines stress as an 'adverse reaction people have to excessive pressures or other types of demand placed on them'.³ Work-related stress is thus understood to occur when there is a mismatch between the demands of the job and the resources and capabilities of the individual worker to meet those demands. This definition emphasises the relationship between individuals and their working environment, and helps to explain why a situation that one person regards as a stimulating challenge causes another to experience a damaging degree of stress.

The degree of stress an individual experiences is, to an extent, dependent upon his/her own appraisal of the demands of their work. Such a subjective appraisal will in turn be affected by a range of socio-economic factors, many of which may not be directly work-related. For example, gender, race and age all play a part, as do geographic location, housing, health, number of children, family arrangements and community networks. In addition, more specific psychological factors must be considered, including past experiences and personality traits. Finally, stress levels seem to depend on what a person interprets as threatening or challenging, and whether that individual believes him or herself able to cope with it. All of these social and psychological variables may profoundly affect individual experiences of stress, so much so that stress appears, ultimately, to be 'in the eye of the beholder'. For this reason, it is arguable that subjective and self-reported evaluations of stress are just as valid as objective data such as statistics on accidents or absenteeism.

A recent report by the National Association of Mental Health⁴ confirms that the individual worker's 'personality and coping strategy' can have direct, moderating or perceptual effects on stress outcomes. For example, an extroverted person might find a socially isolating job more stressful than an introverted person, who

³ Headline statement on the HSE's website at <http://www.hse.gov.uk/stress/>

⁴ MIND, 'Stress and mental health in the workplace', Mindweek report, May 2005

conversely, might find a job with greater levels of social interaction more difficult and stressful. Moreover, a worker's past experience, individual characteristics and personal resources appear to influence how she or he interprets and manages the specific conditions and demands of the job.

The National Association of Mental Health report also draws an important distinction between stress and pressure. Pressure is defined as a subjective feeling of tension or arousal that is triggered by a potentially stressful situation. Because it stimulates mental alertness and motivation, pressure may have a positive impact on employee performance and satisfaction. However, when this pressure becomes extreme, persistent and unrelieved, it may lead to irritability, fear, frustration, aggression and stress, and may even contribute to a variety of short or long term physical and mental illnesses. When pressure exceeds an individual's ability to cope, the result is stress.

1.2 Explaining stress

Although the experience of stress is subjective, and is mediated by the personal evaluation of a situation by the individual, there are nevertheless a number of substantive factors that can be identified as potential causes of work-related stress. These, of course, will vary in degree and importance depending on the particular job, but the HSE has identified six categories of potential stressors⁵:

Demands: This includes factors intrinsic to the job such as working conditions (for example noise, temperature, lighting or ventilation), shift work, long or unsociable hours, workload.

Control: How much say and autonomy a person has over the way in which he carries out his job; low levels of job control are typically linked to high levels of stress.

Relationships: Relationships with superiors, subordinates and colleagues can all play a part in an individual's stress levels;

⁵ HSE, *A business case for the Management Standards for Stress*, HSE Books, 2006

low levels of trust and support are likely to increase stress. Also, conflict, harassment and bullying in the workplace are all linked to heightened stress.

Change: The way in which change is introduced, managed and communicated to staff can impact on levels of stress, as unnecessary or badly planned change results in excess pressure on workers.

Role: Stress may be triggered when an individual does not have a clear understanding of his role within the organisation, when there is conflict between roles or ambiguity with regards to position and degree of responsibility over others.

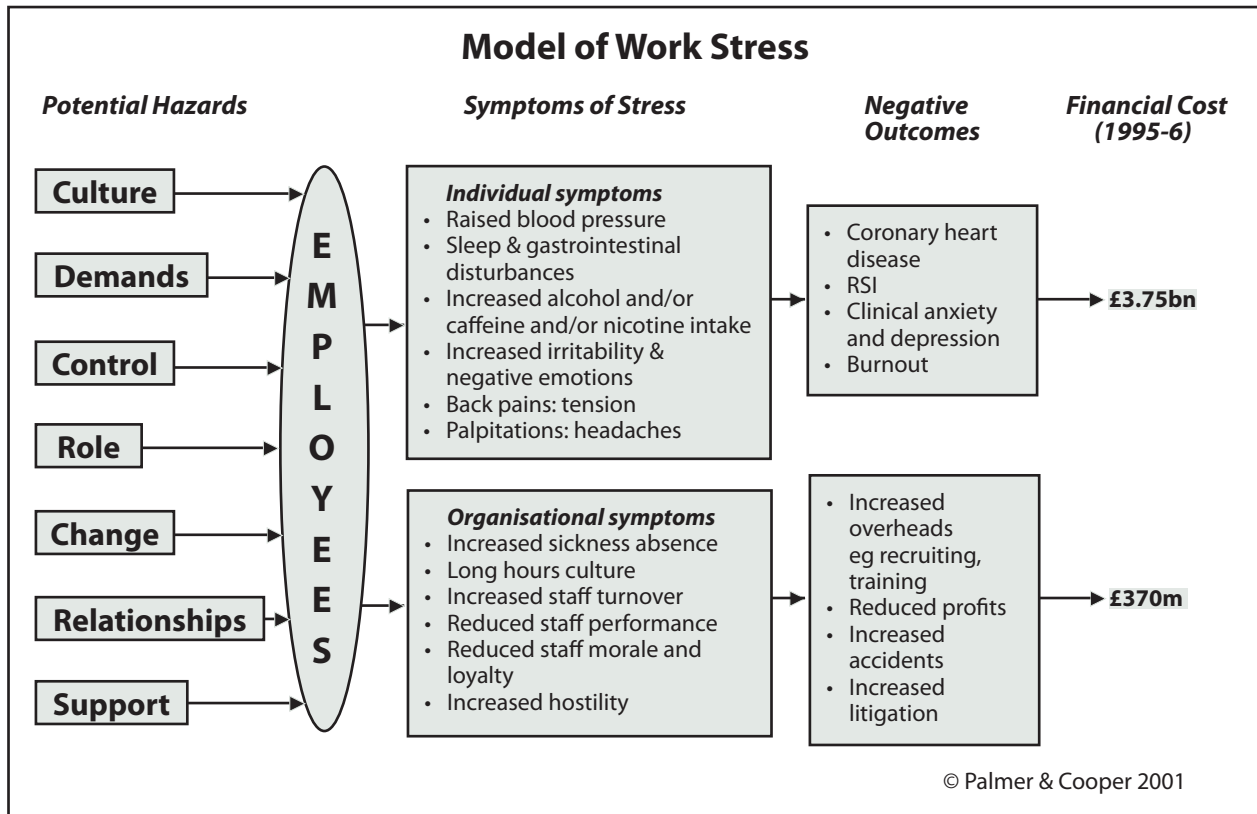
Support: The amount of support and job training available, as well as encouragement, sponsorship and resources provided by colleagues and management.

Another potential risk factor not included in the six HSE categories of stressors is the interface between work and home, often referred to as the work-life balance. Individuals who work long, uncertain or unsocial hours may find it difficult to juggle the competing demands of work and domestic pressures, particularly if they have children or other dependants. This can lead to a 'vicious cycle' in which mounting stress in one area of life spills over and makes coping with the other yet more difficult.

Utilising these potential stress risk factors, Palmer et al⁶ have developed a model of work-related stress that has helped to inform the HSE's current approach to stress management and prevention, and is indicated by the diagram below. It should be noted that in this model a further, seventh driver of stress is identified – culture – which is not identified as an explicit stressor by the HSE but which Palmer et al describe as 'the culture of the organisation and how it approaches and manages work-related stress when it arises'.

⁶ Palmer S, Cooper C and Thomas K, 'Model of organisational stress for use within an occupational health education/promotion or wellbeing programme – A short communication', *Health Education Journal*, Vol. 60 No.4, 2001

Figure 1: Model of work-related stress



1.3 Stress and ill-health

Work-related stress is widely held to be linked to a variety of physical and mental disorders, either by directly contributing to ill-health, or by increasing the tendency for those affected by stress to engage in behaviours that lead to illness and disease. It can be difficult to prove a direct causal link between work-related stress and physical and mental ill-health, as the majority of diseases and syndromes commonly attributed to stress have multiple causes; that is, they are caused by the interaction of a wide variety of factors. Therefore, work-related stress may be one of many components in a causal pattern of morbidity, and its role will vary; sometimes its contribution is insignificant, sometimes it can have an impact in ‘tipping the balance’, thus triggering the symptoms of a disease or accelerating its course.⁷

⁷ EC DG, *Guidance on work-related stress: ‘Spice of Life – or Kiss of Death?’*, Employment and Social Affairs, 1999

The effects of work-related stress on ill-health operate in a number of ways:

Physiologically: nervousness, endocrinal or immunological reactions within the body can lead to symptoms of physical and mental illness.

Cognitively: working conditions and situations are interpreted by the individual as 'stressful' and therefore pathogenic.

Emotionally: seemingly trivial incidents are experienced as debilitating, dangerous, or even life-threatening.

Behaviourally: excessive work strain encourages potentially damaging behaviours, such as smoking, alcoholism, eating disorders, or self-harm.

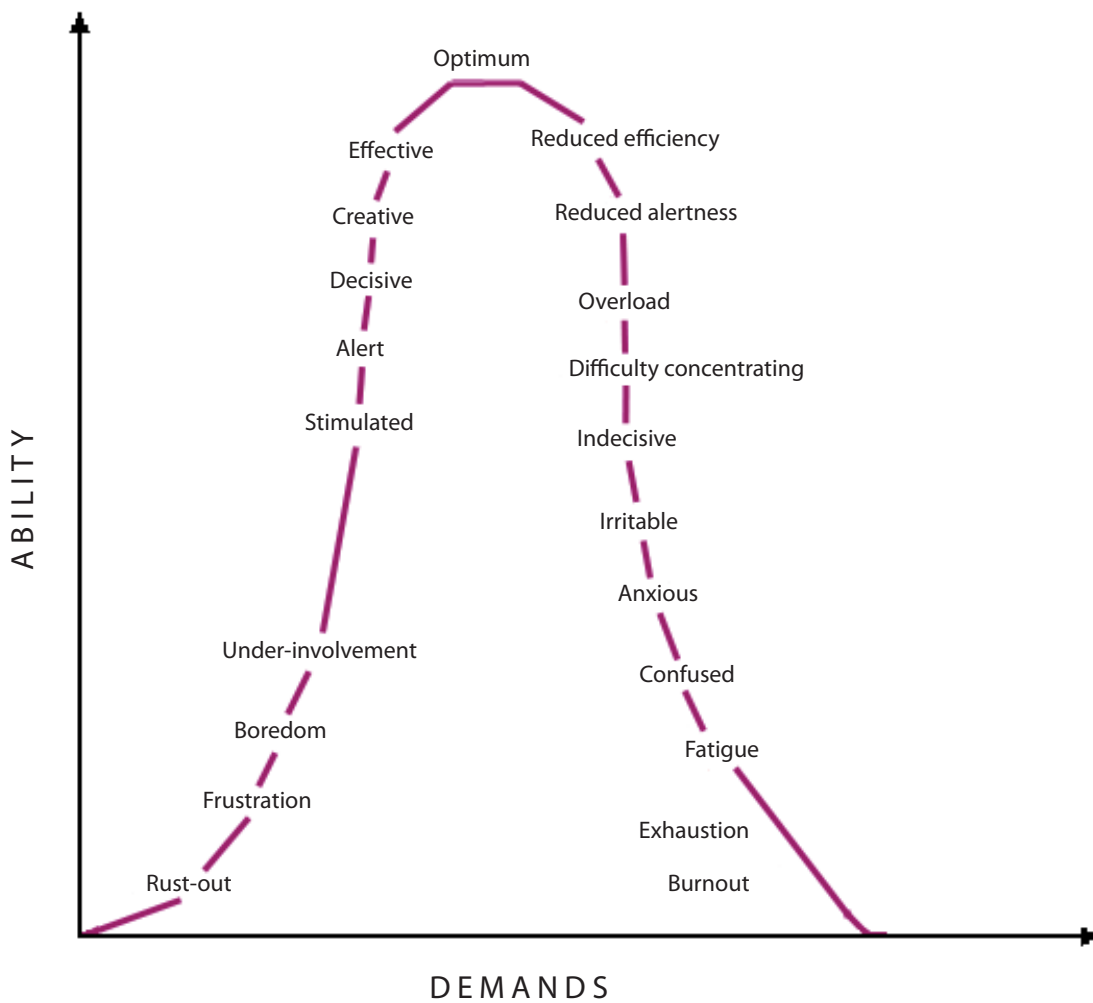
1.3.1 Physical ill-health

The immediate effect of stress on the body is to trigger a natural biological response to challenging or threatening events – frequently referred to as the 'fight or flight' response. When the individual encounters a potential stressor, blood flow is redirected from the skin and internal organs to the muscles and the brain; glucose and fatty acids are mobilised into the bloodstream to provide energy; vision and hearing are sharpened and alertness is increased. The functioning of routine bodily maintenance such as digestion, restorative processes and the immune system are all reduced. Although this stress response is a normal, evolutionary reaction to a perceived threat, when it occurs frequently or is prolonged, intense or poorly managed, it can pose a risk to health.

The suppression of the immune system under chronic stress leads to the 'general adaptation syndrome' which results in a generalised risk of greater susceptibility to illness and disease. Depending on the vulnerabilities of the individual in question, it may also contribute to

a range of medical, psychological and behavioural disorders, all of which are detrimental not only to physical and mental well-being, but also to job performance, productivity, absence levels and staff turnover.

Figure 2: The impact of workplace demands on physiological and psychological performance



Source: Stress UK

When stressful situations are not resolved and persist for some time, the body is kept in a constant state of alertness and defensive action, increasing wear and tear on biological systems, resulting in damage and exhaustion. During the 'fight or flight' response, the immune system is weakened, increasing vulnerability to illness and compromising the body's ability to repair itself and defend itself against disease.⁸ Short term symptoms include headaches, muscular tension, chest pains, indigestion, palpitations, disturbed sleep and increased susceptibility to respiratory infections. Long term illnesses attributable to work-related stress include heart disease, hypertension, ulcers, irritable bowel syndrome, high cholesterol and increased risk of cancer, diabetes and asthma.⁹

Although work-related stress alone probably does not cause cancer, it is known to contribute to a number of stress-related behaviours that secondarily increase the risk of developing cancer. In particular, these include: smoking, excessive alcohol consumption, overeating or consuming too much fatty food.

1.3.2 Mental ill-health

There is a strong relationship between work-related stress and mental ill-health – excessive and persistent stress can trigger and escalate mental illness. Psychological problems that are frequently brought on by work-related stress include: fatigue, low self-esteem, irritability, depressive and acute anxiety disorders and post-traumatic stress disorder.¹⁰

MIND (2005) states that *perceived* job stress is essential to understanding and explaining the worker's mental health¹¹, in other words, explanations do not reside solely in the existence of objective work stressors such as shift work or long working hours. This is not to say that the stressed worker is responsible for his own

⁸ National Institute for Occupational Safety and Health, *Stress at Work*, U.S. Department of Health and Human Services, 1999

⁹ Chartered Society of Physiotherapy, *Employment Relations & Union Services: Health & Safety – Workplace Stress*, CSP, 2004

¹⁰ Chartered Society of Physiotherapy, *Employment Relations & Union Services: Health & Safety – Workplace Stress*, CSP, 2004

¹¹ MIND, 'Stress and mental health in the workplace', Mindweek report, May 2005

plight, but rather that working conditions and individual perceptions of those conditions must be understood together. Most importantly, the views and experience of the person suffering stress should be acknowledged and taken seriously.

Table 1: Effects of stress on bodily functions

	Normal (relaxed)	Under pressure	Acute pressure	Chronic pressure (stress)
Brain	Blood supply normal	Blood supply increased	Thinks more clearly	Headaches or migraines, tremors and nervous tics
Mood	Happy	Serious	Increased concentration	Anxiety, loss of sense of humour
Saliva	Normal	Reduced	Reduced	Dry mouth, lump in throat
Muscles	Blood supply normal	Blood supply increased	Improved performance	Muscular tension and pain
Heart	Normal rate and blood pressure	Increased rate and blood pressure	Improved performance	Hypertension and chest pains
Lungs	Normal respiration rate	Increased respiration rate	Improved performance	Coughs and asthma
Stomach	Normal blood supply and acid secretion	Reduced blood supply and increased acid secretion	Reduced blood supply reduces digestion	Ulcers due to heartburn and indigestion
Bowels	Normal blood supply and bowel activity	Reduced blood supply and increased bowel activity	Reduced blood supply reduces digestion	Abdominal pain and diarrhoea
Bladder	Normal	Frequent urination	Frequent urination due to increased nervous stimulation	Frequent urination, prostatic symptoms
Sexual organs	Male: Normal Female: Normal periods etc.	Male: Impotence (decreased blood supply) Female: Irregular periods	Decreased blood supply	Male: Impotence Female: Menstrual disorders
Skin	Healthy	Decreased blood supply, dry skin	Decreased blood supply	Dryness and rashes
Biochemistry	Normal – oxygen consumed, glucose and fats liberated	Oxygen consumption increased, glucose and fat consumption increased	More energy immediately available	Rapid tiredness

Source: Melhuish, Executive Health

The research undertaken by MIND suggests that certain perceptions of job stress are more likely than others to lead to psychological problems such as anxiety or depression. These aspects include: a perception of a 'poor relationship with a superior' or a perception of 'too much trouble at work'. There also appears to be a heightened risk of employees suffering from a psychiatric disorder when they have little say or control over how their work is done; when their work is fast paced; has conflicting priorities or when they feel there is a lack of recognition, understanding and support from managers.¹²

The effects of psychiatric disorders brought about by work-related stress are significant, both for the individual concerned and for the employer. Anxiety, depression and other emotional problems commonly lead to sickness absence, medical consultations and treatment and high levels of suffering and dysfunction.

In sum, though the word 'stress' now forms part of most people's daily vocabulary, its reach and meaning remain unclear. In popular usage, stress is used to describe individual responses to innumerable everyday pressures, as well as to larger life events. In addition, stress is frequently seen as an important factor in the development of a range of psychological and physical ailments. At the workplace, the term is now widely deployed by both management and workforce to describe individual and collective experiences of fatigue, distress and an inability to cope with the demands of work.

This section has provided a series of working definitions and charted the changing meanings and usages of 'stress.' In the following section we turn to more quantitative evidence in order to examine the latest facts and figures on occupational stress. This evidence sheds further light on the divergence between popular discourses and a more robust, evidence driven understanding of stress.

¹² Ibid

2. An epidemic of stress?

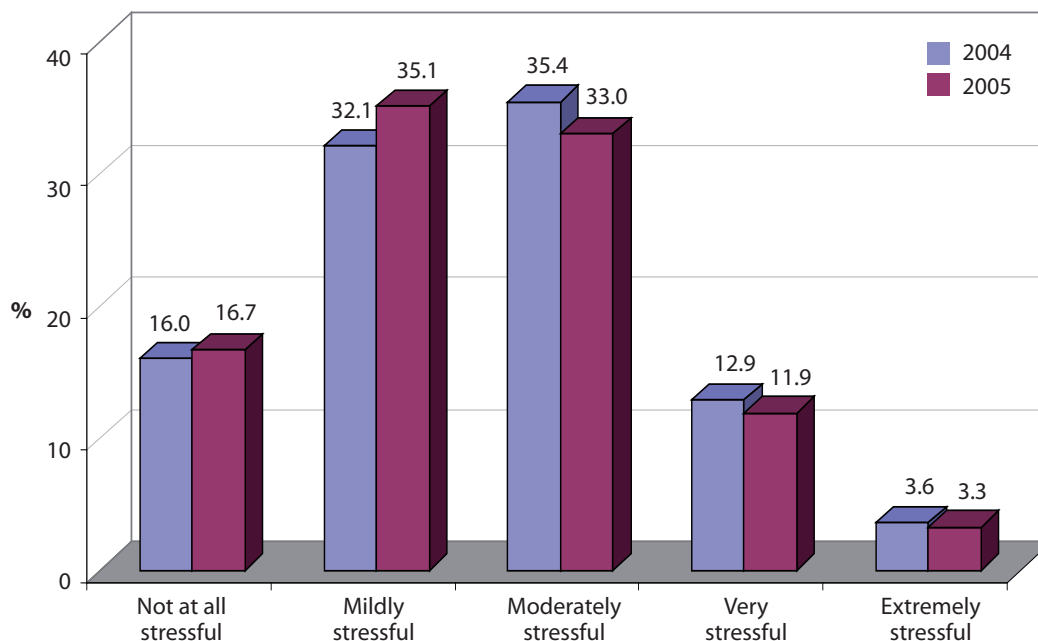
This section examines available data about work-related stress. Its aims are to establish how prevalent work-related stress is in the UK; what differences there are in the prevalence of stress across a range of demographic variables – including occupation, age, sex, ethnicity, type of job and industrial sector, and what the main drivers of work-related stress are in the UK. The intention is to provide a general picture of the extent and distribution of stress in the UK in the light of popular anecdotal evidence, noted earlier, that point to an apparent epidemic of work-related stress in UK.

2.1 The extent of stress

According to the Health and Safety Executive, in 2005:

- More than 500,000 people in the UK believed that they were experiencing work-related stress at a level that was making them ill.
- 245,000 people first became aware of work-related stress, depression or anxiety in the previous 12 months.
- 15% of all working individuals thought their job was very or extremely stressful, a slight reduction on the previous year.

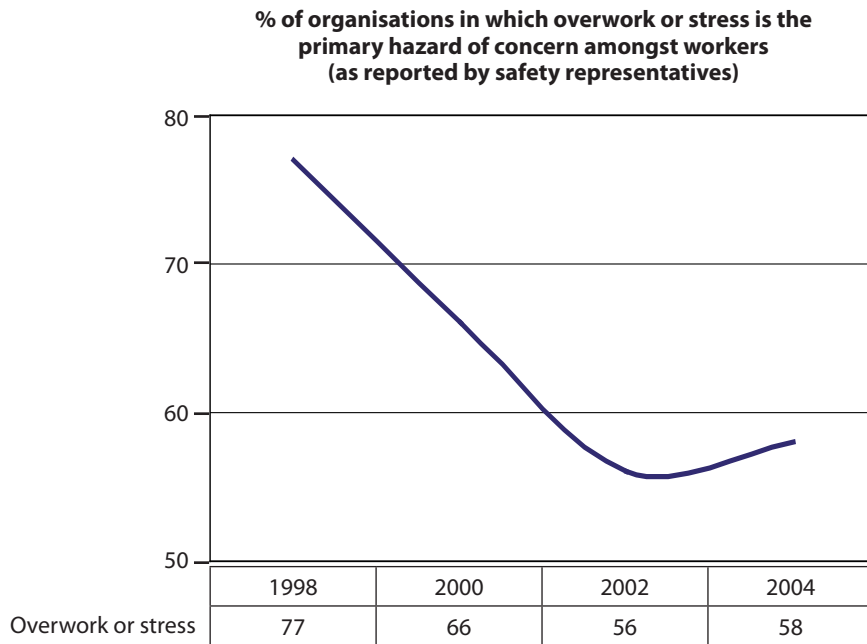
Figure 3: How stressful is your work environment?



Source: Health and Safety Laboratory & HSE

Whilst stress remains the primary hazard of concern for workers Figure 4 shows that levels of such concern have fallen significantly since 1998.

Figure 4: Overwork concern in organisations



Source: TUC, 2004

2.2 The costs of stress

Estimates of the total cost of stress and stress-related illness vary enormously. This is largely the result of the different methodologies used to arrive at a final figure. Recent estimates range from **£5 billion** (TUC) to **£7 billion** (IPD) to **£12 billion** (CBI).

Self-reported work-related stress, depression or anxiety account for an estimated 12.8 million reported lost working days per year in Britain (Source: HSE).

After musculoskeletal disorders, stress is by far the largest contributor to the overall number of days lost as a result of work-related ill-health in the UK.

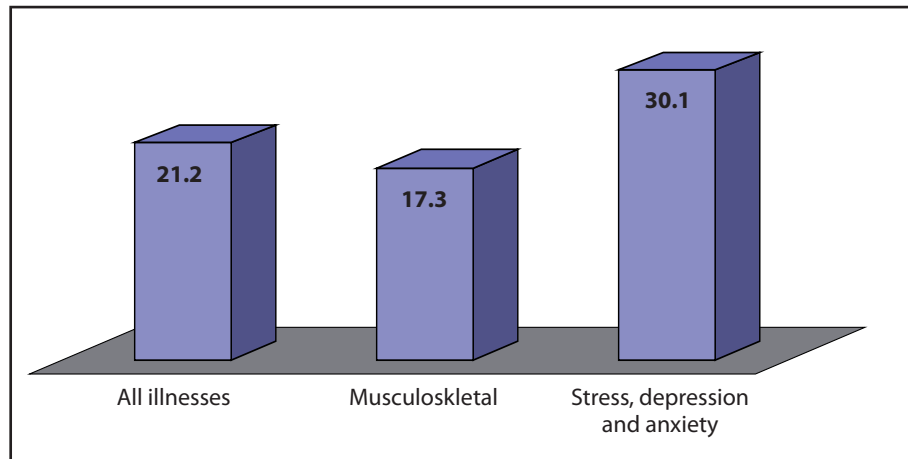
Figure 5: Self-reported illness accentuated by work



Source: HSE

Stress is also, on average, the costliest of all work-related illnesses in terms of days lost per case.¹³

Figure 6: Estimated days lost (FTE) per case due to self-reported work-related injury or illness



Source: HSE

2.3 The victims of stress

2.3.1 Age and sex

Figure 7 shows that the majority of cases of work-related mental ill-health occur in those aged 35-44 and 45-54 years. However, there is a noticeable difference in the distribution of cases amongst men and women. While there are more cases (both relatively and absolutely) amongst women in the 25-34 years age group, cases amongst men surpass those of women (both relatively and absolutely) in the 35-44 years age group.

2.3.2 Full- vs. part-time employment

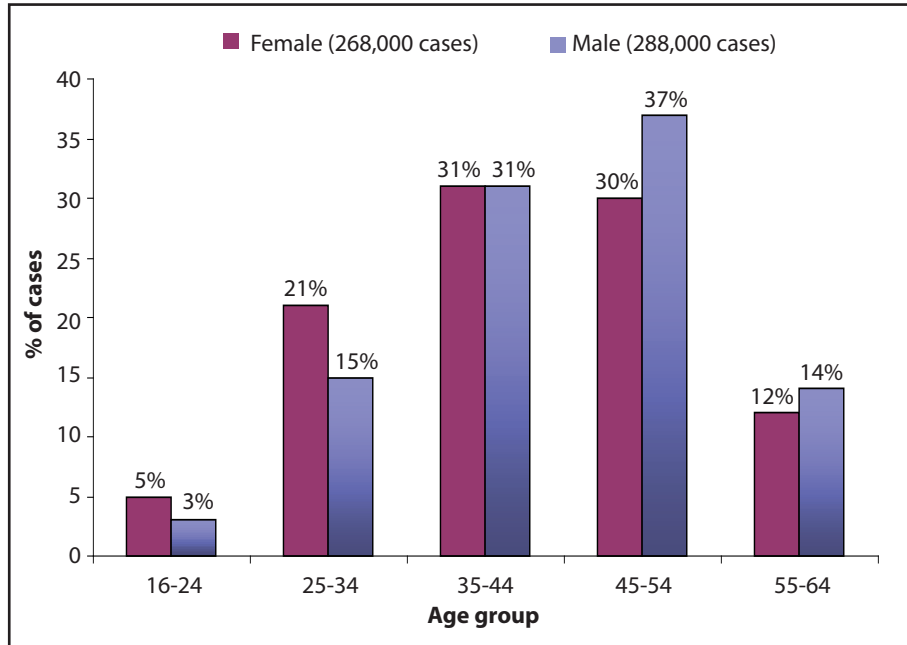
Full-time employment is associated with greater levels of stress than part-time employment. While 21.7% of full-time workers reported high levels of work-related stress, only 8.8% of part-time workers did the same.¹⁴

¹³ SWI 05/06 Table 1 HSE: <http://www.hse.gov.uk/statistics/tables/0506/swit1.htm>

¹⁴ Smith A, Brice C, Collins A, Matthews V and McNamara R, *The scale of occupational stress: A further analysis of the impact of demographic factors and type of job*, HSE Contract Research Report No. 311/2000, 2000

Figure 7: Work-related mental ill-health

Age distribution of cases reported by psychiatrists and occupational physicians 2002-2004

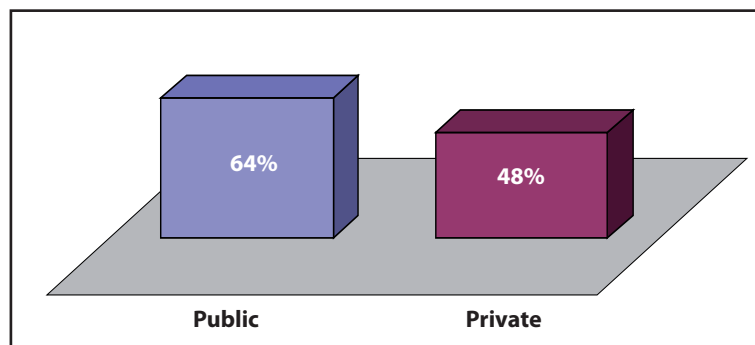


Source: HSE

2.3.3 Public vs. private sector workers

Public sector workers are significantly more likely to report stress to be the leading hazard of concern at work than workers in the private sector (Figure 8).

Figure 8: Percentage of organisations where workers identify stress to be the leading hazard of concern by sector

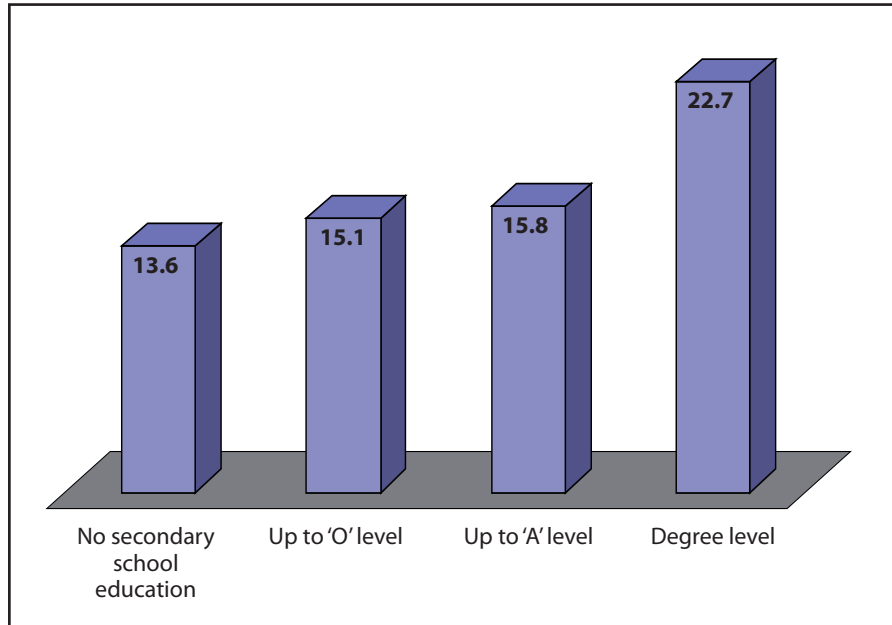


Source: TUC

2.3.4 Education

Stress levels rise in line with higher levels of educational attainment.

Figure 9: Percentage reporting high levels of work-related stress by educational attainment

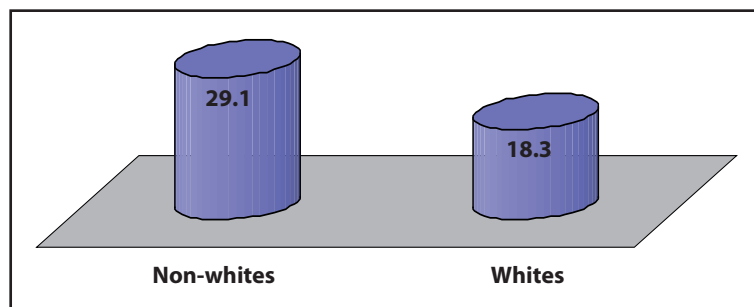


Source: Smith A et al, *The scale of occupational stress: A further analysis of the impact of demographic factors and type of job, 2000*

2.3.5 Ethnicity

Stress is significantly more prevalent amongst black and minority ethnic workers than white workers.

Figure 10: Percentage of workers reporting high levels of work-related stress by ethnicity



Source: Smith A et al, *The scale of occupational stress: A further analysis of the impact of demographic factors and type of job, 2000*

2.3.6 Occupation

Backing up a range of earlier survey data, recent research undertaken by the HSE suggests that the following occupations continue to suffer particularly high instances of work-related stress:¹⁵

- nursing
- teaching
- administrators in government and related organisations
- healthcare and related personal service personnel
- medical practitioners
- prison and police officers
- armed forces personnel.

2.4 The causes of stress

According to the TUC's biennial survey of safety representatives across a range of industries in the public and private sectors¹⁶, workload is the most pervasive factor linked to work-related stress. However, there appears to have been little change in the relative importance of any of the factors linked to work-related stress since 2000 (Figure 11 on the next page).

Workload

The problem of workload is greater in the public sector (83%) and the voluntary sector (77%) than in the private sector (73%). Workloads are identified as a particular problem in education (88%); central government (85%); health services, local government and banking, finance and insurance (all 83%).¹⁷

Cuts in staff

Cuts in staff are a particular problem identified by safety representatives in central government (69%); and banking, finance and insurance (59%).

Change

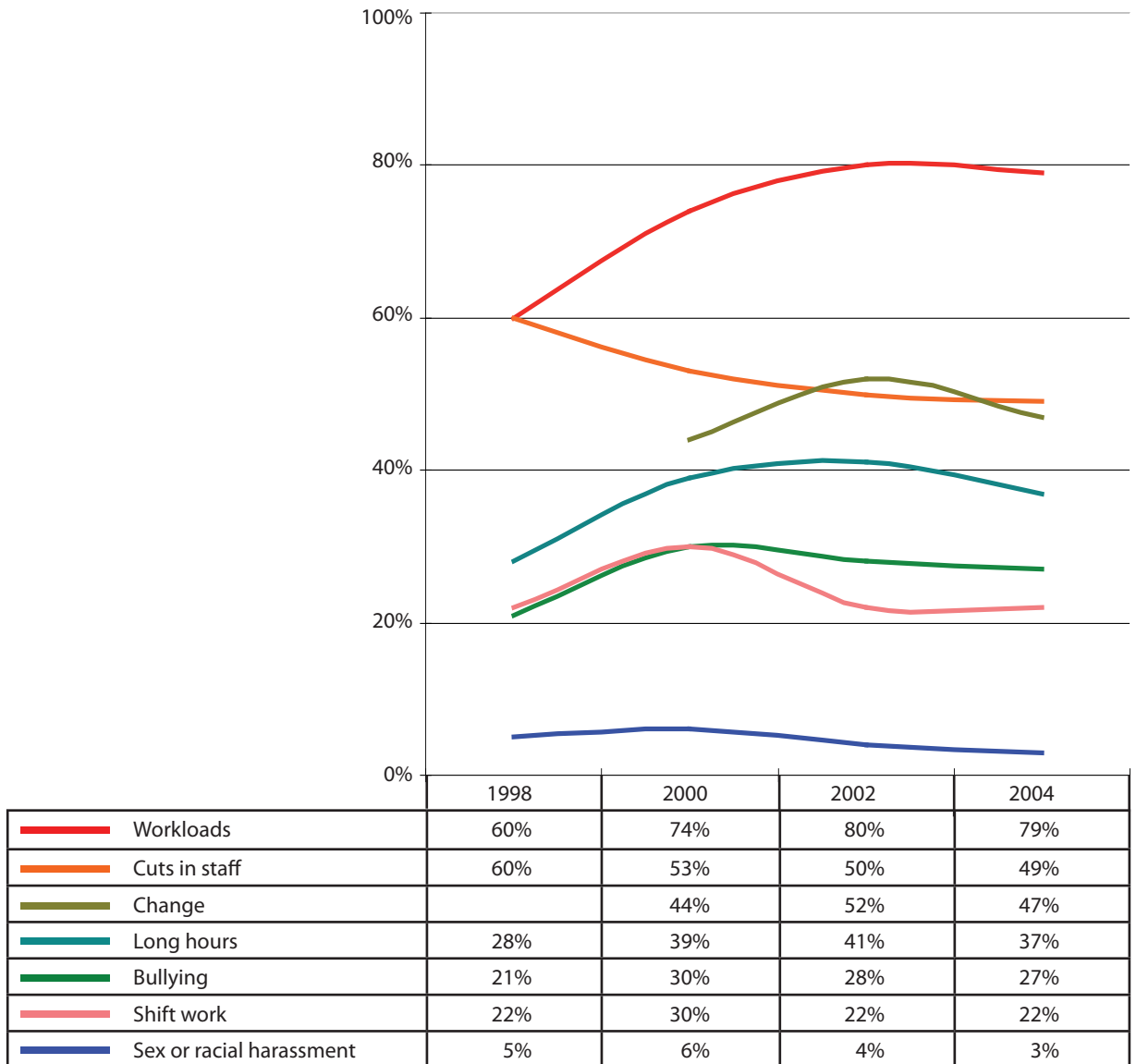
Change was identified as a particular problem more often in the public (51%) and voluntary sectors (54%) than in the private

¹⁵ Health and Safety Executive, Labour Force Survey: Self-reported work-related ill health survey, 2004-2005 (see summary at <http://www.hse.gov.uk/statistics/causdis/stress.htm>)

¹⁶ TUC, *Focus on Health and Safety*, Trade Union Trends Survey 04/03, 2004

¹⁷ TUC, *Focus on Health and Safety*, Trade Union Trends Survey 04/03, 2004

Figure 11: Factors linked to work-related stress as reported by trades union safety representatives



Source: TUC, 2004

sector (39%). For individual sectors, change is a particular problem identified by safety reps in central government (66%); and the voluntary sector (63%).

Long hours

The problem of long hours is identified more often in the private (41%) and voluntary sectors (44%) than in the public sector.

Bullying

Bullying is seen as an increasing problem by safety representatives in central government (40% increasing from 37%) and local government (37% increasing from 33%).

Shift work

Three individual sectors which identified shift work linked to overwork or stress were distribution, hotels and restaurants (48% - increasing from 34% in 2002); transport and communications (43%); and manufacturing (41%).

Sex or racial harassment

The percentage of safety representatives mentioning sex or racial harassment linked to overwork or stress declined to 3% in 2004, compared with 6% in 2000. The percentage of safety representatives mentioning sex or racial harassment is higher in the voluntary sector (8%) and central government (6%).

The data presented above suggests that popular perceptions of a stress epidemic amongst UK workers are probably accurate. The sheer ubiquity of stress-related ill-health (and its associated costs) amongst UK workers confirms this. Nevertheless, the evidence also suggests that while levels of stress amongst UK workers remain very high, they appear to have peaked in the late 1990s and early 2000s and then stabilised. The evidence above also shows that certain industrial sectors, occupations, and demographic variables (particularly around age and ethnicity) give rise to an uneven distribution of work-related stress within the population as a whole.

An epidemic of stress?

The following sections interpret the statistics presented above, focussing on why, if there is an epidemic of stress, it should be occurring now and whether such an epidemic betrays a wider political and cultural unease amongst workers around their relationships to work.

3. Why now?

Whether seen as being due to objective or subjective causes, no one denies that stress now concerns us more than it used to. The question immediately arises as to what, in contemporary life, might be responsible for this sudden increase in visibility? Many researchers have highlighted elements in modernity, post-modernity or late-capitalism, that may be contributing to notions of stress. In this section, we examine this material, and examine in detail the contributions of Richard Layard and Michael Marmot - two thinkers who have made particularly influential and provocative interventions in the debate.

3.1 Stress, work and contemporary life

Stress and common mental health problems typically have complex and multiple causes and cannot be attributed solely to events in the workplace. Certainly, unemployment is as bad or worse for our health, while the fact of having a job, however imperfect it may be, brings positive psychological effects.¹⁸

Barley and Knight argue that the rise in the popularity of stress amongst the general public is largely attributable to its 'broad-based explanatory value, as it can be invoked to account for a variety of negative environmental factors, feeling states, physical sensations and cognitions.'¹⁹

Cooper suggests that it is, in part, a result of an increasingly modern and mobile society, where traditional ties of community, family, neighbours, friends etc. are no longer so strong.²⁰ Furthermore, during the 1990s, we have seen a rise in imposed stress as a result of massive downsizing in companies in both the private and public sectors. This has resulted in heavier workloads, job insecurity and a changing balance between men and women in the workforce.²¹ Other factors might include greater pressure, a faster pace of life

¹⁸ Jones F and Bright J, *Stress: Myth, Theory and Research*, Pearson Education, 2001

¹⁹ Barley S and Knight D, 'Toward a cultural theory of stress complaints' in Staw B and Cummings L (eds.), *Research in Organizational Behavior*, JAI Press, 1992

²⁰ Cooper C, 'The psychological implications of the disposable workforce: the future stressors' in Pearce J, 'Taking the stress out of work - Conference Synopsis', *Stress News*, Vol.13 No.4, 2001

²¹ Jones F and Bright J, *Stress: Myth, Theory and Research*, Pearson Education, 2001

Jones F and Bright J, *Stress: Myth, Research and Theory*, Prentice Hall, 2001

and increased materialism in industrial and post-industrial societies. However, given the 'high levels of mortality and morbidity in many non-industrialised societies, it is very hard to see any basis for the claim that such a lifestyle is any less stressful'.²²

Jones and Bright further argue that it seems hard to 'substantiate a claim that the modern western workplace is more stressful than work in the past, (eg in coal mines or cotton mills)'.²³ Of course, it may be that comparing different historical eras in this way is not particularly meaningful, but it certainly has rhetorical power.

Importantly, it has been suggested that the increase in illness attributed to stress may in part be due to the raised awareness of stress that has taken place only recently. Stress might, therefore, be a particular reflection of historical context²⁴, and even of current political ideology²⁵. Whether real by nature or social construction there is abundant survey evidence that people perceive themselves to be under increasing levels of stress, particularly in the workplace. Interestingly, those who find their work particularly stress-inducing are high- and low-status workers.

As the stress phenomenon has been popularised, less stigma has come to be attached to admitting feelings of stress or inability to cope. Increasingly, we interpret events and emotions in terms of stress. This growing legitimisation has been much assisted by representations of stress in the media, the professionalisation of stress treatments ('medicalisation' of workplace problems²⁶) and a culture in which it can be a matter of pride to describe one's job as having a high degree of stress.²⁷

²² Ibid

²³ Ibid

²⁴ Hobfoll S, *Stress, Culture and Community: The Psychology and Philosophy of Stress*, Plenum Press, 1998

²⁵ Lewig K and Dollard M F, 'Social construction of work stress: Australian newsprint media portrayal of stress at work, 1997-98', *Work and Stress*, Vol. 15 No. 2, 2001

²⁶ Harkness A, Long B, Bermbach N, Patterson K, Jordan S and Kahn H, 'Talking about stress at work: Discourse analysis and implications for stress interventions', *Work and Stress*, Vol.19, No.2, 2005

²⁷ Jones F and Bright J, *Stress: Myth, Theory and Research*, Pearson Education, 2001

Jones F and Bright J, *Stress: Myth, Research and Theory*, Prentice Hall, 2001

If job positions are perceived to be undervalued or not respected, then this also may affect individual and collective perceptions of stress.²⁸ Claiming one's work to be stressful can be a way of establishing solidarity within a professional group or organisation. It may even be used as a strategy for claiming benefits like higher pay.

Some researchers have gone so far as to suggest that stress is merely a figment of our collective and perhaps over-enthusiastic imagination. We are myth-making beings, and it should not surprise us that, 'it would appear that society has built up a complex folklore about stress which is reinforced by popular culture and the media.'²⁹

Stress has certainly become strongly linked to discursive constructions of identity and value. In ordinary language we speak of stress often, and use it to describe our experiences. Yet there is also a wide-ranging sociology of stress, with voluminous literature variously attributing stress to cultural changes surrounding new communication technologies, consumerism and the sheer rapidity of social change. Others have suggested that it is the socio-cultural shift towards 'post-modernity' that explains the emergence of stress. As Bracken suggests:

'within the cultural horizon of late or post-modernity individuals live their lives without recourse to firm foundations. While this offers unprecedented freedom for individuals to define their own identities, their relationships and their beliefs about the world, it also brings with it a burden of what Giddens (echoing Heidegger and Laing) calls "ontological insecurity". In times of trouble this insecurity can become intense and at times unbearable.'³⁰

²⁸ Harkness A, Long B, Bermbach N, Patterson K, Jordan S and Kahn H, 'Talking about stress at work: Discourse analysis and implications for stress interventions', *Work and Stress*, Vol.19, No.2, 2005

²⁹ Ibid

³⁰ Bracken P, 'Post-modernity and post-traumatic stress disorder', *Social Science and Medicine*, Vol. 53 No.6, 2001

Fear, of course, is nothing new. We have long known that no one gets out of here alive, yet on no occasions at all do we find our ancestors using the language of stress to describe their many predicaments. Clearly however, the forms of insecurity do change over time, as do the conceptual languages we use to articulate their effects. Stress is such language. Its emergence and growing use both *makes and discovers* its object, at one and the same time. In some ways, therefore, stress can be seen as an affective language (following the work of French social theorist Michel Foucault) with which we increasingly articulate the injuries of work.

Whether real or imagined, stress feels real, can be measured and is a significant cause of unhappiness. This connection between stress and unhappiness has greatly interested researchers, in particular, the economist Richard Layard, who argues that increasing happiness and reducing stress should become the objects of public policy management.³¹

3.2 Stress and happiness

In his influential work, *Happiness: Lessons from a New Science*, Layard examines the causes of human happiness and puts forward suggestions as to how it might be increased.³² His central argument is that richer societies are not necessarily happier ones, and that rather than focusing on economic growth or measurements of productivity, economists and policy makers ought instead to address the question of how to make people feel happier.

Layard notes the seeming paradox in Western societies that despite huge increases in income and resources, people do not feel happier. Levels of happiness are no higher than they were fifty years ago despite average incomes having doubled. In addition, many countries now have higher rates of depression, alcoholism and crime. Layard seeks to address the question of why happiness is not increasing in Western societies, in order to make policy recommendations about how to promote it.

³¹ Layard R, *Happiness: Lessons from a New Science*, Allen Lane, 2004

³² Layard R, *Happiness: Lessons from a New Science*, Allen Lane, 2004

Layard's work is, in many ways, a reconstruction of Benthamite utilitarianism. He advances the idea that the ultimate goal of both the individual and society should be the promotion of the greatest happiness for the greatest number and he similarly holds that a felicific calculus (a mathematics of feeling) is both possible and desirable. Happiness is here seen as self-evidently good, universally desired and indeed, the primary factor in human motivation. It is thus the ultimate end which renders all other goods valuable.

Layard asserts that increasing the long term happiness of its citizens should be the principal goal of government. Moreover, he claims that the widely held belief that human happiness cannot be quantified or measured has allowed conventional economists and policy makers to overemphasise people's market behaviours and to orient to the wrong measurements; something he holds to have been the case with the Gross National Product.

For Layard, human happiness is both objective and quantifiable. He argues that recent developments in the fields of psychology and neuroscience make it possible to measure happiness, and that we can now relate people's statements about how they are feeling to changes in the brain. Neuroscientists have identified the left frontal lobe of the brain as the area where good, happy feelings are experienced, and the right frontal lobe as the site of negative, unhappy feelings. There is a strong correlation between the emotions people report and activity in these areas of the brain, signifying that happiness is an objective and measurable phenomenon. In addition, greater happiness is conducive to better physical health, so that happy people have stronger immune systems and lower levels of the stress-inducing hormone cortisol than unhappy people.

Layard presents empirical evidence to demonstrate that increased wealth and prosperity do not necessarily make for happier citizens.

Although people living in rich nations do tend to be happier than people living in poor ones, Layard suggests that the measure of happiness added by extra income is greatest when you are very poor and so where it lifts you out of sheer physical poverty. However, above a certain threshold (around \$20,000 per head), higher levels of income do not generate a significant increase in reported levels of happiness. Again, in the United States, Western Europe and Japan, rates of clinical depression, alcoholism, crime and stress have actually risen.

Layard offers several reasons why increased prosperity is not accompanied by increased happiness. First, surveys have shown that we have a tendency to compare our income and resources with those of our peers, so that it is not absolute but *relative levels* of wealth that mainly influence our degree of happiness. We compare our income with that of those around us, so that while we may have more disposable income in absolute terms than we did fifty years ago, we feel no better off, for now our neighbours do too. Moreover, it requires people to sacrifice much of their leisure time in order to work harder to try and increase their wealth *in comparison* with their neighbours.

Layard further argues that we gradually adapt to our increased wealth, becoming habituated to a higher standard of living. It no longer seems a luxury, but rather a basic requirement and as such, it ceases to augment our happiness. Simultaneously, while we are working harder to maintain our status and generate more income, relationships with families, friends and colleagues suffer. At the larger community level, as overall prosperity increases, social inequalities become more pronounced. Specifically, people who are socially disadvantaged or excluded lose more in status, self-respect and happiness than the rich gain from their growing wealth.

Layard identifies what he calls the 'Big Seven' factors affecting happiness: family relationships, financial situation, work, community

and friends, health, personal freedom, and personal values. Most significant here is the issue of work, which is essential to happiness not just for the income it provides, but for the added meaning it brings to life, and the self-respect and social relationships it creates. Unemployment is disastrous for individual happiness not only because of the loss of income, but because work makes us feel needed and productive. Crucially, Layard holds that the work we do must be fulfilling and offer a genuine experience of autonomy and creativity. Although our earnings are important, the respect of our peers, and the capacity to exercise control over our work, remain powerful motivating factors.

While work is a clear source of self-respect and happiness for the individual, Layard accepts that it may also generate stress and unhappiness. However, this too he attributes to our inherent desire for social status. Indeed, the pressure to lift our status may be so great that it can impact on our physical health. In support of this, Layard cites Michael Marmot's work (see below), which shows that highly ranked civil servants secreted lower levels of the stress-related hormone cortisol than those in the lower grades.

Layard believes we need to tame the stressful 'rat race,' which exerts constant pressure on us to improve our wealth and status as compared to others, and yet is a zero-sum game that can never enhance societal well-being or happiness. Every time we raise our income or status in relation to others, we may diminish their income or status, and consequently, their happiness. The rat race is, therefore, individually and collectively destructive: 'we lose family life and peace of mind in pursuing something whose total cannot be altered', while at the same time, the zero-sum game is a 'waste from the point of view of society as a whole.'³³

For this reason, Layard contends that the reduction in social inequalities resides in measures that work to restore a healthier work-life balance and that prevent people working ever harder

³³ Layard R, 'Happiness Is Back', *Prospect*, Vol.108, 2005

to accumulate wealth and boost their status. Regarding work, Layard argues that stress reduction requires greater security in employment and improved working conditions. Although economic theory and policy frequently advocate 'flexibility', 'innovation' and 'mobility' in the workforce in order to increase productivity and efficiency, this is experienced as instability and insecurity for the individual, and can be extremely detrimental to happiness and well-being.

Layard proposes a public policy that aims to augment human happiness by promoting security, co-operation and family-friendly work arrangements. Workplace and public policies should derive from a clear recognition of how labour mobility and job insecurity impact on employees, families and communities. Layard also calls for more resources to tackle problems of depression, stress and mental illness, and advocates the greater availability of NHS funded psychiatric treatment and therapy.

The traditional and established political objectives of economic growth and productivity are here deposed. Layard's work advocates a fundamental shift in thinking about employment and social policy, one that moves away from traditional political and economic goals, and towards a politics informed by a concept of the common good; namely the greatest happiness for the greatest number.

Layard conceives of work-related stress as an obstacle to happiness; as indeed, a cause of unhappiness. He therefore accepts a rather loose definition of stress, mixing in elements of pressure and excitement and not concerning himself with its precise nature. This then becomes part of a larger concern about happiness itself, for it is by no means clear that such a concept can sustain real examination. Happiness certainly has a powerful everyday meaning, but the clarity required to guide social policy so far eludes it.

3.3 Stress and social status

In *Status Syndrome*, leading epidemiologist Michael Marmot examines how and why our social standing affects our health and longevity.³⁴ His project is to identify the ways in which we can alleviate social disparities in order to improve public health. Marmot seeks to explain why it is that almost all psycho-social and biomedical risk factors to health are more prevalent among people of lower socio-economic status (SES). *Status Syndrome* holds that, (1) health follows a social gradient, improving at each level of the socio-economic hierarchy; (2) relative inequality, more than any particular level of income or resource, determines the incidences of illness and death within any socio-economic group; (3) this is because higher relative levels of SES give rise to greater autonomy or control, and greater social integration and participation.

Marmot's argument draws upon the findings of his analysis of the health of 100,000 British civil servants. This research concluded that there was a dramatic difference between the health and life expectancy of those at the top of the hierarchy and those at the bottom. In addition, there was a clear gradient showing improved health, lower stress levels and a longer life expectancy among people at each higher level of the hierarchy. This trend was surprisingly consistent, so that other risk factors to health such as smoking, blood pressure, physical activity, or obesity accounted for only a third of the variation. Marmot claims that this social gradient exists not only within the ranks of Whitehall civil servants, but across the entire population. For example, people with Doctorates live longer than those with Master's degrees, while Oscar winners live on average four years longer than those who were nominated but did not win. In other words, our position in the social hierarchy has profound consequences for our well-being and longevity.

Significantly, Marmot shows that these differences are not merely a result of the higher income and increased access to medical care and other resources enjoyed by those at the top of the hierarchy. Instead, they are a reflection of the extreme disparities in status and

³⁴ Marmot M, *Status Syndrome*, London, Bloomsbury Publishing, 2004

severe social segregation that exist at the national level and work to undermine public health. Above a certain minimum threshold, it is relative, not absolute deprivation that makes a difference to people's physical and mental health. This is because status inequalities produce varying (and unequal) experiences of self-determination and social participation.

'For people above a certain material threshold of well-being, another sort of well-being is central. Autonomy – how much control you have over your life – and the opportunities you have for full social engagement and participation are crucial for health, well-being, and longevity. It is inequality in these that plays a big part in the social gradient in health. Degrees of control and participation underlie the status syndrome.'³⁵

Marmot suggests that income is not solely a measure of wealth and access to material possessions. It is also a way of 'keeping score' of one's social value and position. Social status is a vital determinant of health and longevity. Those with higher status will exercise greater control over the conditions of their lives and will enjoy enhanced opportunities for social integration and participation. This can take the form of rewarding relationships, access to a community and the respect of peers. Those of a lower SES are less likely to enjoy these advantages and are, therefore, more apt to suffer a loss of autonomy. External forces beyond their control have greater power over their lives, while social support networks are less stable. This results in greater insecurity and a decreased ability to influence the events that impinge upon life. According to Marmot, it is these conditions, rather than the fact of a lower income, that may produce chronic stress resulting in poor physical and mental health. (This is a view supported by Twenge et al who have found a significant increase in feelings of powerlessness in the face of rapid socio-economic and cultural change amongst young Americans since the late 1960s. They argue that the implications of this shift are almost wholly negative, resulting in lower levels of well-being, a greater

³⁵ Marmot M, *Status Syndrome*, London, Bloomsbury Publishing, 2004

likelihood of depression and anxiety and a reduced capacity to cope with stress).³⁶

Marmot's position derives from a different conception of stress than the traditional understanding of the term, one that fits more clearly with his contention that sickness and stress are associated with lower, rather than higher social status. In conventional definitions stress is often related to how busy a person is, arising from the juggling of numerous important responsibilities, deadlines and obligations. Thus stress finds an association with high status and positions of social or occupational importance. Marmot departs from this perception, associating increased stress with the lack of agency that goes with positions of lower status. Stress, so conceived, refers to a corrosive situation in which the individual feels that choices are limited and that there is little opportunity to influence events and situations. It is this type of stress, Marmot believes, that is a determining factor in the disparity in health prospects across different socio-economic strata.

A related cause of work-related stress derives from a disparity between the effort required to complete work and the rewards for completion. For this reason, people require not only a sense of autonomy in their employment, but work that offers pleasure, fulfilment and opportunities for individual creativity. Those who labour in dull, dead-end jobs suffer from an imbalance between work and rewards. This is detrimental to their physical and mental well-being, making them more likely to engage in harmful behaviours such as smoking or excessive drinking.

Marmot argues that the most effective and affordable policies to improve public health are not those that are targeted at the medical system, but instead are those which seek to reduce income and educational inequalities, protect workers and their families, provide access to safe housing and environments, and promote care for children and the elderly. Empirical evidence supports his assertion

³⁶ Twenge J M, Zhang L and Im C, 'It's Beyond My Control: A Cross-Temporal Meta-Analysis of Increasing Externality in Locus of Control, 1960–2002', *Personality and Social Psychology Review*, Vol. 8 No. 3, 2004

that in times of greater economic polarisation, the longevity gap increases, whereas in periods of social equality and a more equitable distribution of resources the longevity gap decreases. In the 1970s, for example, the difference in life expectancy between the highest and lowest social groups was 5.5 years; by the 1990s, following a decade of Thatcherism and neo-liberal economic policies, the gap had grown to 9.5 years, but is now narrowing again.

Marmot's framework challenges traditional understandings of stress, as it puts forward the idea that people in seemingly stressful, high-status jobs may not actually be suffering from stress. In fact, they are able to exercise greater control over their work and have better access to supportive social networks. Policies to improve public health are not, therefore, simply a matter of medical intervention, but require action to mitigate the effects of the social gradient, and to reduce its slope so that its effects on health are not felt so acutely by those at the bottom.

This section has situated the problem and discourses of stress in its contemporary context, beginning with an overview of recent historical changes in work and living patterns that may impact on its meaning and occurrence. In particular, the provocative interventions of Richard Layard and Michael Marmot offer conceptual approaches that could have profound implications for workplace planning, economic and social policy. Recently, however, public and academic understandings of stress have been animated by more sceptical investigations. Challenging questions and problems concerning methods and measurement, work-related stress and the therapeutic culture are now firmly on the table. These issues will be addressed in section four.

4. The sceptics

Despite the wider explanatory advances signalled by the work of authors such as Layard and Marmot, there is also a growing scepticism amongst other commentators regarding much of the evidence presented for rising levels of stress and the implications. In particular, doubts have been raised about existing approaches used to measure stress and also about the political and cultural implications that follow from claims that stress levels are inexorably rising. Here, the widespread usage and popularisation of the term have prompted some observers to argue that greater attention should be paid to the role that stress plays within our wider political and popular cultures.

This section opens with an overview of methodological and measurement problems associated with research into stress. This then provides the basis for a more detailed examination of two recent and particularly influential interventions that raise doubts about the reality: those of medical sociologists David Wainwright and Michael Calnan and cultural sociologist Frank Furedi. With these commentators, debates about stress begin to take on a larger political significance.

4.1 Problems of method and measurement

4.1.1 One of the main methods of data collection for the study of stress is self-reporting. This raises questions concerning the reliability of the data because self-reporting relies on the perception of the person doing the reporting.

Associations between occupational stress and ill-health arising from self-reporting are problematic because these associations may be explained by other factors, such as job attitudes or 'reverse causation' (where, for example, poor health causes a deterioration in actual or perceived working conditions).³⁷ In addition, self-reporting may not be sufficiently reliable to establish evidence of causation, especially where stress is claimed but not accompanied by changes in physiology. Whilst self-reporting allows us to gather information on an individual's perception of their environment and their reactions to it – thus providing valuable insights into subjective

³⁷ Smith A, Johal S, Wadsworth E, Davey Smith G and Peters T, *The Scale of Occupational Stress: The Bristol Stress and Health at Work Study*, HSE Contract Research Report No.265/2000, 2000

interpretations of experience – it poses significant methodological difficulties. Self-reporting confronts problems of accurate memory, self-evaluation, language ambiguity and even the desire of subjects to present themselves in a particular light.

4.1.2 Differentiating between stress that is work-related and that which is related to non-work factors is important but problematic.

Studies show that although many employers are able to identify causes of stress in their employment sector they still believe that stress originates in the personal lives of employees. Employers thus seek to retain the distinction between life and work. However, research has largely discredited this 'myth of separate worlds,' and argues that there is no longer a firm boundary between life and work. The collapse of this boundary begs the question of whether the stress experienced in response to workplace stressors is of the same kind as that encountered in other environments (eg the family), or whether it is, in fact, a result of inter-domain conflict and 'spillover' (eg job-family).³⁸

We can try to differentiate between stress in different spheres of life by examining the roles that are required for each sphere and identifying where potential conflicts might lie. Such conflicts may be affected by time-based factors (eg long working hours, frequent business trips which reduce time spent at home), strain-based factors (such as spillover of strain from one area of life to another), or behaviour-based factors (where the behaviours required in one role are incompatible with those required in another). However, whilst the 'myth of separate worlds' has been largely discredited, it is still possible to classify certain types of stress as occupational or non-work related, even though this will not cover the many types that involve interactions between the two. Occupational stress might result from factors at an organisational level, such as organisational function and culture; or at an individual level, where it concerns issues such as decision latitude/control, working

³⁸ Cooper C, 'The psychological implications of the disposable workforce: the future stressors' in Pearce J, 'Taking the stress out of work - Conference Synopsis', *Stress News*. Vol.13 No.4, 2001

hours, organisational role, career development or interpersonal relationships at work.³⁹

4.1.3 Traditional methods of assessing risk and physical hazards cause problems when applied to stress.

While established risk assessments are effective when the cause-effect relationship is known and the risk is discrete, the psychological nature of the stress process, and in particular, the uncertainty about the relationship between hazard and harm, means that a traditional risk assessment and management approach may not be appropriate. Also, stressors may have different meanings for different individuals, thus making it more difficult to develop objective metrics. While some may rate a job as stressful on the basis of how they perceive the objective nature of the work (the stimulus), others will only concern themselves with how it makes them feel (the response). Moreover, measurement techniques that fail to differentiate between the occurrence of events (demands) and the individual's appraisal of their significance for his or her well-being present still further difficulties.⁴⁰ This reiterates the subjective nature of the problem and the difficulty of developing risk assessments that can accurately identify the factors causing employee stress.

4.1.4 Data on stress is often over-reliant on a single measurement; most often, self-reported incidents and experiences.

In order for self-reports to be considered reliable, they should be validated through correlation with other factors, such as changes in behaviour, physiology and health. Such measures might include 'objective indicators' such as physical tests (biochemical, haematological tests, cardiovascular parameters or measurement of mental performance) or information from clinical assessments. Other data, such as levels of absenteeism or accident statistics, may be useful, as might health-related behaviour such as smoking or alcohol consumption. An audit of the working environment is also

³⁹ Cox T, *Stress Research and Stress Management: Putting Theory to Work*, HSE Contract Research Report No. 6 1/1993, HSE Books, 1993

⁴⁰ Ibid

recommended to enable comparison between workers' perceptions and other measures of health and job effectiveness.

Where both stressors and strains are measured using the same method (eg self-report questionnaire), the relationships which appear to emerge from the data may in fact be the result of the method itself. Thus, research has increasingly suggested that it is necessary to use a wider range of objective and subjective measures in order to validate the data gathered and so provide more reliable interpretations. Gathering data from multiple sources also allows other influencing factors to be taken into account. Triangulating a range of methods may also help to generate more effective stress management interventions.

4.1.5 The rise in the 'popularity' of stress is driven in part by cultural change.

This is partly because of its broad-based explanatory value, as it can be invoked to account for a variety of negative environmental factors, physical or emotional feelings. As we have already seen, it has been suggested that individual perceptions of stress have been shaped by changes in modern society where traditional ties of community and family are no longer so strong. In addition, economic and market changes have led to downsizing in companies in both the public and private sector, and therefore heavier workloads for a smaller number of people, job insecurity, greater pressure and a faster pace of life and work.

Individual perceptions of stress may also be influenced by the increasing absence of stigma attached to admitting feelings of stress or an inability to cope. Consequently, this might lead us to interpret events and emotions through the perception that life is stressful. This legitimisation of stress has been aided and validated by its prevalence within the media and the professionalisation of stress treatments. At the same time however, there are those who argue that stress is a myth or an inappropriate term, suggesting

that society has developed a complex folklore about stress which is reinforced by popular culture and the media.⁴¹ Work-related stress also seems to be linked to constructions of identity and value. If job positions are perceived to be undervalued, underappreciated or not respected, either culturally or within the organisation, then this affects individuals' experiences of stress at work.

4.1.6 Confusion over the meaning of stress has hampered advances in treatment and management.

Different conceptualisations of stress have led to the development of different approaches to treatment, for example, interactional and transactional approaches. An interactional framework examines the structure of the relationships between stressors (input) and strains (output) without accounting for individual differences. One such model suggests that job demands and decision latitude (control) interact to influence health. This might be useful from an employment policy-making perspective. Transactional theories suggest that this is inadequate and that we should focus on the 'cognitive processes and emotional reactions underpinning individuals' interactions with their environment'.⁴² They suggest that items cannot be conceptualised as stressors independently of a person's reaction to them. What is stressful for one person (eg moving house) may not be stressful for another. Such an approach may be of real value in providing individual support and help.

The lack of clear statistical or scientific evidence for the links between 'workplace stress' and 'work-caused disease' has prompted employers to question research and so avoid interventions which are impractical, costly, and, at times, unsuccessful.⁴³ Certainly, researchers have not been very successful in effectively identifying and quantifying harm, leaving employers uncertain as to which of the many available theories of stress and interventions has the

⁴¹ Jones F and Bright J, *Stress: Myth, Theory and Research*, Pearson Education, 2001

Jones F and Bright J, *Stress: Myth, Research and Theory*, Prentice Hall, 2001

⁴² Smith A, Johal S, Wadsworth E, Davey Smith G and Peters T, *The Scale of Occupational Stress: The Bristol Stress and Health at Work Study*, HSE Contract Research Report No.265/2000, 2000

⁴³ Australian Chamber of Commerce and Industry, *Stress as a Community and Workplace Issue*, ACCI, 2001

answer.⁴⁴ Different conceptions of stress are likely to emphasise different approaches to intervention, focusing either on the individual (eg stress management training, counselling) or on the organisation (eg organisational restructuring, job redesign). Current models tend to focus on the individual level, assuming that stress can be adequately explained by theories implicitly modelled on the notion of a functional disease. However, as already noted, such emphasis on the physical aspects of stress may ignore cultural influences on how it is perceived.

Moreover, as O'Donnell and Bevan⁴⁵ argue, to approach workplace stress as primarily a matter of health and safety may result in its 'over-medicalisation'. Here, they draw comparisons with the health and safety oriented approach to work-related back pain adopted over the past 30 years. This approach, they argue, has not prevented a huge rise in work-related back injuries but may in fact have encouraged the popular view that back pain is a 'catastrophic' injury that leads (almost invariably) to incapacity. As O'Donnell and Bevan ask 'If catastrophisation leads to more extreme illness behaviour in back pain, what does it do for stress?'

4.2 Putting stress in perspective

In *Work Stress*⁴⁶, David Wainwright and Michael Calnan directly address many of the issues we have been examining. Their aim is to challenge commonly held assumptions about the current 'epidemic' of work-related stress. They argue that conventional ways of thinking about and explaining stress have paid insufficient attention both to the role of the individual worker's consciousness in mediating the relationship between work and illness, and also to the social, cultural and historical context in which rising stress levels have occurred. Their thesis is that:

'the work stress epidemic represents an individualised and historically specific response to adverse experiences at work, in which workers come to internalise their problems as emotional

⁴⁴ Ibid

⁴⁵ O'Donnell M and Bevan S, 'Stress at work: time for a rethink?', *Occupational Health At Work*, Vol.1 No.3, October/November, 2004

⁴⁶ Wainwright D and Calnan M, *Work Stress: The Making of a Modern Epidemic*, Open University Press, 2002

and health issues due to diminished expectation of both resilience and agency'⁴⁷

Their concern is not to show that work-related stress is false or does not exist, but rather 'to demonstrate that it is an historically specific and transitory phenomenon'. The book is therefore intended to 'reveal the historical, structural, cultural and discursive conditions of existence that enable problems at work to be experienced through the prism of the work stress epidemic'. It is also intended to call into question those accounts which conceive of stress as the inevitable product of unsustainable pressures and demands made on workers by late capitalism.

Wainwright and Calnan accept that work-related stress is a real phenomenon which can have genuine physical and psychological symptoms and serious consequences for those who experience it. However, their argument is that many accounts of the causes of rising levels of stress have interpreted stress as the unmediated physiological response to objectively 'stressful' conditions in the workplace, so that a 'stress-related personal injury' can be understood in similar terms to a physical injury sustained at work as a result of faulty machinery or contact with dangerous materials.⁴⁸

Epidemiological approaches to explaining work-related stress, they claim, treat social factors and certain work characteristics (such as high job demands, low job control and low social support) as inherently and objectively pathogenic, so that stress is presented as the natural and inevitable response to the limits of human endurance and resilience being reached. The work-related stress 'epidemic' is, they argue, deeply embedded in the popular imagination, and thus there exists a 'discourse' of work-related stress, with reference to which workers are increasingly making sense of their adverse work experiences as well as their physical ill-health. In other words, although the symptoms and consequences of

⁴⁷ Ibid

⁴⁸ Wainwright D and Calnan M, 'Rethinking the work stress 'epidemic'', *European Journal of Public Health*, Vol.10 No.3, 2000

work-related stress may be real and experienced by the individual, to a large extent it is a discursive construct which affects workers' thoughts and actions, and informs their interpretations of the working conditions and situations they face.

According to this discourse of work-related stress, recent changes in patterns of employment and working conditions – declining job security, longer working hours, lower levels of pay, more coercive management styles – have led to increasing numbers of people suffering from 'work stress', which is broadly understood to entail feelings of pressure and difficulty in coping with one's circumstances. Acceptable responses to this stress epidemic involve regulation and legislation to mediate the effects of changing working patterns and conditions, management strategies to reduce the potential for employees to experience stress in the work place and therapeutic measures to assist individuals to overcome stress when they do encounter it (such as counselling or relaxation exercises). The implementation of these strategies will, according to the received narrative of work stress, result in a healthier, happier workforce, reduced levels of sick leave, fewer compensation claims and increased productivity. However, Wainwright and Calnan take issue with several assumptions inherent in the work stress discourse, arguing that not only is it based upon a flawed and inadequate account of the causes of stress, but also that the policies it recommends as solutions to the problem may actually serve to exacerbate it and render individuals unable to respond in an appropriate and positive manner to adverse experiences at work.

The dramatic increase in the numbers of people suffering from work-related stress in recent years is commonly attributed to changing patterns in employment and working conditions, such as longer working hours, more intensive workloads, or heightened job insecurity. The authors question this assertion and argue that it is based on a narrow and largely ahistorical perspective which compares current levels of stress and working conditions with those

of the mid to late 1970s. They claim that people's working lives were more arduous, dangerous and insecure throughout much of history, for example in the first half of the twentieth century, and yet there was no epidemic of work-related stress.

Another reason they are critical of this explanation is that it locates the origins of stress exclusively in changes at work, to the oversight of other social, political and cultural factors. They point to several wider developments in recent years which have increased the likelihood for an individual to interpret their working conditions as stressful and therefore to report to be suffering from the ill effects of stress. In the political context, they highlight the changing role and influence of trade unions: as the unions' power to affect government policy has declined, they have repositioned their activities away from political demands and towards health and safety issues; this has encouraged the unions and their members to reconsider problems of workplace relations through the lens of health and safety, and to reinterpret what were previously considered to be political issues, such as overwork, low levels of pay or poor working conditions, as medical or psychological problems, the solution to which is not industrial action but a trip to a doctor or counsellor. In other words, the erosion of the viability of collective solutions to problems and conflicts in the workplace has led to individuals internalising the issue and conceiving of it in terms of their mental well-being and personal inability to cope with the stresses of their job.

In addition, Wainwright and Calnan argue that socially and culturally, there has, in recent years, arisen both a heightened awareness of physical and mental vulnerability, and a growth in what they describe as a 'culture of victimhood' and the 'therapeutic state.' This trend towards a greater emphasis on emotions and mental well-being, they argue, encourages workers to interpret their experiences at work in personal and emotional terms, as well as to consider any ill-health they might suffer as originating in their state

of mind and inability to respond appropriately to the pressures of their job.

Significantly, where their approach differs from typical discourses about stress is that Wainwright and Calnan emphasise that the relationship between objective conditions in the workplace and the individual's health and well-being is mediated by subjective factors, particularly the consciousness of the individual affected and the way in which they interpret the events and conditions of their work. Whilst the symptoms of stress are embodied and may be to a certain extent objective and measurable, there is a crucial element of perception, cognition and reflection on the part of the individual, and for the most part diagnoses of work stress are based on the self-reported physical and mental effects of the individual concerned. What one worker may experience as unbearable pressure and sickening levels of stress may, for another, be enjoyed as a stimulating challenge. Levels of resilience and tolerance will vary from person to person depending on a wide range of social and cultural experiences. Compounding this are the facts that virtually any adverse work experience, ranging from mild discomfort to physical assault, can be identified as a source of stress, and that the physical and psychological symptoms commonly held to be brought on by stress all have multiple and complex causes. It therefore becomes extremely difficult, if not impossible, to establish a relationship of cause and effect between a set of objective work characteristics and symptoms of stress. Thus:

‘the work stress epidemic comprises an allegedly causal relationship between an extremely wide range of putative pathogens and an equally diverse range of health and behavioural effects, and this relationship is primarily mediated by consciousness.’

It then becomes problematic to develop strategies that might prevent such stress from occurring.⁴⁹

⁴⁹ Wainwright D and Calnan M, *Work Stress: The Making of a Modern Epidemic*, Open University Press, 2002

Wainwright and Calnan are concerned that the reconceptualisation of workplace problems in terms of stress and the individual's inability to cope with it, lead to proposed cures that have the effect of lowering our expectations regarding human resilience, accentuating the worker's sense of vulnerability and causing feelings of frailty and powerlessness. When adverse work situations are drawn as instances of an individual's failure to respond appropriately to the stresses and pressures of their job, the solutions proposed are therapeutic interventions such as counselling or medical treatment. The authors argue that such interventions are ultimately damaging as they reinforce the underlying notions that work is inherently hazardous, and that individual subjects are weak, passive and unable to actively control the circumstances of their own lives. The current focus on therapeutic strategies is thus leading to the dangerous emergence of a new identity – the 'work stress victim' – who is unable to cope, and therefore, relinquishes sovereignty over her mental health and well-being to a professional. An increasing reliance on therapeutic solutions, they argue, undermines human agency and results in a diminution of the self, whereby individuals are perceived as passive victims who are unable to withstand the demands of work without the assistance of counselling and clinical intervention. Treating work stress as a disease, they believe, will exacerbate the problem by lowering expectations of resilience and 'valorising human frailty'.

Wainwright and Calnan conclude by arguing that theoretical attempts to understand work stress require a 'radical departure from the epidemiological, psychological and physiological approaches' and need to 'conceptualise the interplay of socio-cultural factors, patterns of physiological response and the development of self-identity and resilience over the life course.' Rather than endorsing therapeutic solutions, they seek to advance an 'active form of resistance' of which the 'most likely agent for transformation is the mentally competent, emotionally resilient subject who has high expectations of human potential'.

4.3 Therapy culture?

Many of the above concerns are further examined by the sociologist Frank Furedi who argues that they are representative of a wider and more recent shift in Anglo-American societies towards what he describes as a 'therapeutic imperative'.⁵⁰ By this he means that virtually every sphere of life has become subject to a new emotional culture. His point here is that experiences that would once have been regarded as normal elements of life – disappointment, isolation, tiredness, depression – are now being redefined as 'syndromes' requiring medical intervention. People are no longer considered capable of dealing with the emotions these experiences generate without the intervention of counsellors, therapists or medical professionals.

Furedi holds that the growing domination of therapeutic culture is problematic and dangerous because it promotes a conception of the human subject as weak, fragile and powerless, and recasts individuals as victims. It also serves to devalue and destroy people's relationships, discourages positive action for change and instead, encourages a passive acceptance of the status quo. Finally, therapy culture breeds an authoritarian dependence for one's mental health and well-being on the state and medical professionals.

Furedi claims his criticisms are not directed specifically at psychiatrists and counsellors, but instead at what he sees as a more general trend towards therapeutic and emotional cultural norms wherein it is assumed that people are unable to cope with life's difficulties alone. He thus sees the relentless emphasis directed towards the need to boost our 'self-esteem', and the continual expansion of categories of trauma to encompass more and more of life's experiences as embodying a diminished and fatalistic view of human agency. Under the rubric of therapy, humans are portrayed as suffering from some form of 'emotional deficit' and existing in a permanent state of vulnerability or risk. In an interview, Furedi described his position thus:

⁵⁰ Furedi F, *Therapy Culture: Cultivating Vulnerability in an Uncertain Age*, Routledge, 2003

‘Every culture has a story about the human subject – the values it expects people to aspire to... Our culture’s story is of a weak, feeble person, who is continually at risk, and for whom the chances of things going wrong are very great. Therapy culture represents a shift from the view of the robust, independent person, capable of great individual and collective achievements, to the notion of the fragile, powerless victim in need of continual professional support. Far less is expected of humans in the twenty-first century than was expected in the nineteenth... Today’s society operates around the belief that people can’t cope on their own, or face the challenges of life.’⁵¹

Related to these views on the growth of therapy culture is his attack on what has been termed the ‘politics of happiness’, which is increasingly being adopted by politicians from both sides of the political spectrum. Furedi notes that both government and opposition politicians, influenced by ideas such as those of Richard Layard, are espousing their commitment to pursue policies and strategies designed to promote public happiness and increase our sense of contentment and well-being. Furedi views this social and political emphasis on ‘feeling good’ as a reflection on the fact that ‘the individual self has become the central focus of social, moral and cultural life.’⁵² The pursuit of happiness is regarded as an individual responsibility, and the possibility that this sense of well-being might be achieved through meaningful work, social engagement or civic responsibility is, so Furedi claims, disregarded. Happiness is construed as something that can only originate from within the individual, and ‘things that distract the individual from attending to his emotional needs are devalued.’⁵³

Furedi interprets these strategies adopted by politicians as the ‘politics of behaviour’ and ‘Emotion Management.’ He regards this as an attempt to politicise the personal quest for self-fulfilment, and

⁵¹ Bristow J, ‘Hooked on Self Esteem: an interview with Frank Furedi’, Spiked Online, accessed 1 July 2006 at <http://www.spiked-online.com/Articles/0000006DF70.htm>, 2005

⁵² Furedi F, ‘Why the politics of happiness makes me mad’, Spiked Online, accessed 1 July 2006 at <http://www.spiked-online.com/index.php?site/article/311/>, 2006

⁵³ Furedi F, ‘Why the politics of happiness makes me mad’, Spiked Online, accessed 1 July 2006 at <http://www.spiked-online.com/index.php?site/article/311/>, 2006

as a tactic that has been adopted only because politicians have found themselves 'unable to give meaning to public life'. It is thus an 'approach that substitutes therapeutic intervention for political direction', and should be resisted because it institutionalises the dangerous idea that the public are dependent on a therapeutic government for our own satisfaction and emotional well-being.⁵⁴

There are, Furedi argues, significant and disturbing political implications in handing over responsibility for pursuing our personal happiness to those who govern us. Policies that are designed to make us happy actually have little to do with a genuine emotional response to our experience; instead, he claims, they are an attempt to persuade the public to think positively and adopt forms of behaviour deemed appropriate by enlightened 'experts'. In other words, we are being encouraged to be content with our lives, to be more modest in our aspirations and to lower our expectations, thereby achieving greater personal happiness. This can have profoundly conservative consequences, instilling us with the idea that our grievances or feelings of dissatisfaction are personal problems which can be dealt with through therapeutic interventions aimed at helping us adjust, and thereby preventing us from experiencing these problems as causes for justified anger against the state. The politics of happiness and therapeutically inspired public policies therefore seek to control our behaviour and stifle dissent and unrest. Furedi's claim is that 'cultivating an electorate with low expectations appeals to officials who have very little to say or offer', and that the 'turn towards the management of people's internal life is motivated by moral disorientation and political exhaustion'.⁵⁵ He argues that despite advocates' claims that a therapeutic approach to public policy will result in more caring, altruistic and trusting societies, the emphasis on individual happiness and emotions distracts people from the lives of their communities and turns citizens into helpless patients.

⁵⁴ Furedi F, 'Politicians, economists, teachers...why are they so desperate to make us happy?', The Daily Telegraph, 07/05/2006

⁵⁵ Ibid

Furedi's fundamental conviction is that if 'you can't buy happiness, then you certainly can't produce it through legislation'⁵⁶, and that we must resist the desire by governments and policy makers to adopt the role of therapists who endeavour to heal society and manage emotions. Such proposals he argues, despite their seemingly benign appearance, are profoundly paternalistic, treat citizens as discontented children and are predicated on the notion that individuals are weak and fickle. The consequences of this for the democratic vision of the social contract, in which autonomous and rational citizens hold their government to account, are potentially devastating. For this reason, Furedi states, we should strongly resist attempts by politicians to pursue policies designed to makes us happy, and, 'be suspicious of experts who seek to colonise our internal life.'⁵⁷

⁵⁶ Furedi F, 'Why the politics of happiness makes me mad'. Spiked Online, accessed 1 July 2006 at <http://www.spiked-online.com/index.php?site/article/311/>, 2006

⁵⁷ Furedi F, 'Politicians, economists, teachers...why are they so desperate to make us happy?', The Daily Telegraph, 07/05/2006

5. Legal and policy contexts

Social and political debates notwithstanding, the problem of stress in the workplace requires concrete responses from employers and policy makers. This section surveys the legal and policy contexts in which the workplace stress is being addressed.

5.1 Stress and the law

Employer liability originates in common law. Here, employers are seen to owe a duty of care to their employees. This requires the provision of a safe working environment and their protection from foreseeable risks. The common law duty of care has been extended into legislation which covers the health as well as the safety of employees. It is under this legislation that compensation claims are made. Difficulties in establishing a direct link between the causes and effects of stress has influenced the decisions of the courts in such matters. While no legislation deals directly with stress, there are laws which are relevant to tackling work-related stress. Amongst the most important are:

The Health and Safety at Work Act 1974 requires employers to take effective measures to control the risks of stress-related ill-health arising from their work activities. The Act requires employers to ensure the health, safety and welfare of employees whilst at work, and this includes their mental as well as their physical health. Work-related stress is here considered to be a health and safety issue like any other workplace hazard.

The Management of Health and Safety at Work Regulations 1999 requires employers to carry out regular assessment of health and safety risks in the workplace. Such assessments refer not only to physical hazards, but also to risks around work-related stress.

The Working Times Regulation 1998 limits the length of the working week, regulates rest breaks and makes paid holidays a legal entitlement. The Regulation helps to address some of the main causes of stress, such as long working hours and insufficient rest or holiday.

The Safety Representatives and Safety Committees Regulations 1977 gives safety representatives extensive legal rights to investigate and tackle workplace stress. Such rights allow representatives to gather information from management concerning sickness and accidents which may be useful in identifying particular causes or patterns of stress. They can also gather information from employees and address health and safety complaints. The Regulations give health and safety representatives the right to organise workplace inspections to identify causes of stress.

The Workplace (Health, Safety and Welfare) Regulations 1992 covers conditions in the workplace such as temperature, lighting, cleanliness, ventilation, space, drinking, washing and rest facilities, which can all be causes of workplace stress if not properly provided and maintained.

European Directive 89/391 supports existing guidelines and reiterates that employers have a duty to ensure the health and safety of workers. The duty is here held to cover work-related stress and its causes as well as other risks to health and safety.

Under the *Disability Discrimination Act 1995*, an employer can become liable for treating an employee less favourably on the grounds of disability if that disability is a depressive illness resulting from stress at work. The Act also requires employers to make reasonable adjustments to working conditions or to the workplace in order to avoid putting disabled workers at a substantial disadvantage.

The Employment Rights Act 1996 is the most common legal basis for a bullying claim, which it understands in terms of a breach of the duty of care by an employer. Concern over bullying in the workplace and its relationship to work-related stress has been on the increase over recent years. Bullying can include physical acts, management

style and allocation of work. A successful claim in this context would need to show a breach of the employment contract.

At the European level, a recent non-binding agreement on work-related stress has been reached by employer and employee organisations. The agreement is voluntary, and aims to increase the understanding and awareness of employers and employees about work-related stress. It thus highlights the need to be aware of signs that might indicate stress-related problems. European and UK legislation work with similar definitions of work-related stress.

It is clear, then, that in both UK and European legislative frameworks, there is a requirement to undertake risk assessments for work-related stress and to take measures to control and address identified risks. Generally, it is the employer's responsibility to determine the appropriate measures, which are then carried out with the active involvement and participation of employees or their representatives. These measures can focus either on the individual or on the workplace more broadly. They can target either specific stress factors which have already been identified, or they can be part of a wider stress policy which seeks to embrace both preventive and responsive measures.

5.1.1 Enforcement

The UK Health and Safety Executive (HSE) has produced management standards that are intended to help employers both assess, and take specific measures to control, the risks of work-related stress. Importantly, the HSE has the enforcement powers necessary to ensure that employers comply with their obligations under health and safety legislation. If employers do not comply with their duties, there are a variety of enforcement options available. Certainly, cases can be pursued through the courts, in which case employers face criminal prosecution, imprisonment or unlimited fines. Additionally, employees can claim for personal injury, constructive dismissal or discrimination on grounds of disability.

These types of claims would be likely to go before an employment tribunal.

In response to the increasing number of cases being brought to court, the Court of Appeal has indicated that workers can win damages for stress only if the employer was aware that the employee suffered a previous mental breakdown or that the employee had informed their employer that they might suffer ill-health through stress at work. In other words, the ill-health must be, at least to some extent, foreseeable to the employer. Only when there are clear indications that an employee is likely to suffer harm as a result of occupational stress is the employer expected to act. Courts are not easily persuaded that employers have breached their duty of care as it is difficult to assess the different effects of pressure on individuals. To some degree, this shifts the responsibility from the employer to the employee, for the latter is now responsible for reporting problems. The guidelines issued by the Court of Appeal for use by lower courts indicate that an employer who offers a confidential counselling service is unlikely to be found in breach of their duty of care.

Box 2: Stress and the law: Recent cases

Walker v Northumberland County Council

Despite repeated pleas to his managers for support, Walker, a senior social worker, carried an enormous workload which eventually led to a nervous breakdown. On his return to work he received extra help, but this was gradually withdrawn, after which he had a second breakdown. This led to enforced retirement on the grounds of ill-health.

Walker claimed against his employer (Northumberland County Council) for breach of their duty of care to him. The judge concluded that, although Walker had cited stress as a problem, the employer could not have foreseen that this would lead to the first breakdown. He found, however, that they should have foreseen a second breakdown in similar circumstances, and had breached their duty of care. The case was settled out of court in early 1997 for £175,000 while awaiting appeal.

Lancaster v Birmingham City Council

In July 1999, a former housing officer with Birmingham City Council was awarded more than £67,000 in compensation for work-related stress caused by a job transfer. This case made legal history as it was the first time an employer accepted liability for ill-health caused by stress in a British court.

Lancaster sued the council after she became depressed and demoralised, and eventually retired on medical grounds after taking long periods of sick leave. She had been moved from her job as draughtswoman to work as a neighbourhood housing officer. In addition to dealing with members of the public who were often intimidating and abusive, she was not given sufficient administrative support, and had a high workload, partly as a result of an unfilled vacancy. She said she was expected to do the job without ever having been given proper training.

North v Lloyds Bank

A former bank worker was awarded more than £100,000 in an out of court settlement in August 2000 after suffering post-traumatic stress disorder, the first such case in the banking industry.

North, a former financial advisor, was diagnosed as suffering from post-traumatic stress after being put under intolerable pressure to meet increasing sales targets by his managers at Lloyds Bank (now Lloyds TSB). He complained to his managers, but was offered no support.

Benson v Wirral Metropolitan Borough Council

A teacher who was forced into early retirement as a result of work-related stress was awarded £47,000 in an out of court settlement from the local education authority in September 1999.

Benson claimed that Wirral Metropolitan Borough Council had exposed her to a foreseeable risk of injury, even though she had complained about her workload, amounting to 66 hours a week, and warned that she was under too much stress.

Contd....

...Contd.

Hatton v Sutherland

In a composite judgement in 2002, the Court of Appeal considered the cases of four employers appealing against the award of damages to four employees who had developed psychiatric illnesses caused by stress at work. Two of the claimants were teachers in comprehensive schools, the third was an administrative assistant at a local authority training centre, and the fourth was a raw materials operative at a factory. The Court of Appeal allowed the employers' appeals in three of these cases (Hatton, Barber and Bishop) and in so doing, set out a number of practical propositions for the guidance of courts concerned with this type of claim in the future. These include:

- An employer is entitled to assume that an employee can withstand the normal pressures of the job unless s/he knows of some particular problem or vulnerability
- There are no occupations which should be regarded as intrinsically dangerous to mental health
- Employers are generally entitled to take what they are told by employees at face value and do not have to make searching enquiries about the state of their health
- Employers who offer a confidential advice service, with referral to appropriate counselling or treatment services, are unlikely to be found in breach of duty.

Barber v Somerset County Council

Barber, a school teacher, suffered a mental breakdown at school in November 1996, since then he was unable to work again as a teacher. Following a restructuring of staffing at the school in 1995, he had worked long hours, and towards the end of 1995, he had begun to feel the strain. He had consulted his doctor about 'work stress' and had been off work due to 'overstressed/depression' for three weeks in May/June 1996. He had spoken to the headmistress and her two deputies about his troubles, but he had been treated with inadequate sympathy and nothing had been done to assist him.

The original tribunal ruled that Barber had been given little help even though the school's senior management was aware of the stress he was under. In 2002, the Court of Appeal, as part of the Hatton v Sutherland ruling (see above), found that Barber's employers had not breached their duty to him and said that the school had not been required to check whether he was still suffering from stress, despite knowing of a previous illness. It quashed the original award of £101,041 in damages and interest.

In 2004, that decision was overturned by the House of Lords, which awarded Barber £72,547 in damages and in a 4-1 judgment decided that Barber's employer was in continuing breach of the duty of care by failing to lessen the job-related stress from which he was suffering.

Nevertheless, the House of Lords ruling also endorsed the practical propositions laid down by the Court of Appeal in Hatton v Sutherland describing them as 'a valuable contribution to the development of the law'. However, for O'Donnell and Bevan (2004), the principles established in Hatton v Sutherland – in particular, that no occupation is inherently more stressful than another and that stress pertains to the individual rather than the workplace – seem directly at odds with the position adopted by the Health and Safety Executive in the development of its Management Standards on stress (see Section 5.2 below).

Sources: Chartered Society of Physiotherapy, Employment Relations & Union Services: Health & Safety – Workplace Stress, 2004 & The Law Society of England and Wales

5.2 Stress and public policy

A set of general factors are commonly identified as useful in the reduction and management of work-related stress. These include effective people management, good two-way communication between employers and employees, appropriate working environments and effective work organisation.

These general factors are then reflected in the development of more specific methods of stress reduction and management in the UK workplace. In the UK, the HSE plays the central role in tackling workplace stress. The primary focus of the HSE is on prevention rather than cure.

Increasingly, government, employer and employee organisations have come to recognise the importance of work-related stress and of constructing effective policy responses to tackle it. At the European level, this is being undertaken through the voluntary agreement referred to above. As in the UK, the European agreement aims to raise awareness and understanding of work-related stress among both employers and employees, and to develop measures for stress reduction and management in the workplace. The European approach, like that of the UK's HSE, is based on risk assessment and management. So do they share a growing preference for prevention.

In partnership with both employers and employees, the HSE has sought to develop tools and guidance to help organisations address the issue. When assessing potential hazards in the workplace, the HSE requires ill-health that arises from workplace stress be treated the same as ill-health arising from other physical causes. The key tool produced by the HSE is its *Management Standards, 2004*. Although the standards are voluntary and do not have legal status, they offer clear guidance to organisations and buttress existing legislation. The HSE has indicated that non-compliance with the standards will be used as evidence against employers if they continue to ignore their responsibilities under the *Health and Safety at Work Act 1974*.

In working towards these management standards, emphasis is placed on participation and partnership between employers, employees and their representatives in order to develop effective and practical solutions which are relevant to individual organisations. The standards focus on the six broad areas already outlined in Section 1 above, (demand, control, relationships, change, role and support). The standards will mainly be assessed through questioning employees on their satisfaction with each of the six areas. Once problems have been identified, employers and employees work together to identify and develop solutions. Organisations then set out a clear action plan, indicating what steps need to be taken and how. This might include, for example, further training for managers, provision of information or a timeframe for review.

HSE management standards tie in closely with longer-standing government commitments to improve health and safety, such as the *Revitalising Health and Safety Strategy*. This is a 10-year plan which sets targets to reduce stress and manage its effects. The HSE also has a 10-year occupational health strategy, *Securing Health Together*, which aims to develop clear standards of good management practice for preventing work related stress. Again, the strategy here is to develop awareness of the issue and its management, and to educate employers about how they can limit work-related stress.

By concentrating on prevention, the HSE intends to reduce stress, and reduce the number of days lost to work-related ill-health. It also provides opportunities for rehabilitation and recovery for people unable to work due to ill-health or disability; something it does through back-to-work programmes and the provision of guidance for both employers and employees. The HSE focuses on those employment sectors with the highest reported levels of work-related stress, these being: health, education, central government, local government and financial services.

Whether employers are sceptical about the nature of stress in the workplace or not, the changing legal and policy context clearly places growing responsibility upon them to contribute to its prevention and management. The legal responsibilities of employers are increasing, and the costs of stress continuing to rise (in regard to lost working days). Thus, there are now significant pressures on employers to become more fully informed about stress and to make effective interventions towards its reduction. It is to research on such practical interventions that we now turn.

6. Interventions

6.1 What does the evidence say?

Workplace interventions and strategies for the management of stress can typically be classified into three groups: primary, secondary and tertiary. Primary management strategies aim to prevent work-related stress arising, targeting the employee, the job or the interface between the worker and the workplace. Secondary approaches attempt to minimise the impact of stress and diminish the seriousness of its consequences, and therefore tend to be focused on the individual worker. Tertiary stress management strategies involve identifying and treating the ill effects of stress once they have occurred, and rehabilitating the individual to enable them to return to work as swiftly as possible.

6.1.1 Primary prevention and stress management strategies

Primary management approaches to stress are intended to prevent it from arising in the first place by altering the source of stress. These approaches fall broadly into two types: reactive and proactive. Reactive methods try to identify and change those aspects of either the workplace or the worker that are likely to induce stress. Proactive strategies focus on the workplace itself rather than on the individual employee and attempt to create a working environment that is as stress-free as possible.

In practice, primary approaches have tended to focus on the individual rather than the workplace, for a number of reasons. Proactive interventions are frequently considered to be too expensive or disruptive⁵⁸, and are often seen as more difficult to implement than strategies which focus on the individual. Organisations are also more likely to be comfortable with management strategies that focus on the individual rather than on the workplace, and so programmes aimed at the organisational level are rare.⁵⁹

⁵⁸ Cartwright S, Cooper C L and Murphy L, 'Diagnosing a healthy organisation: A proactive approach to stress in the workplace' in Murphy L, Hurrell J, Sauter S and Keita G (Eds), *Job Stress Interventions*, American Psychological Association, 1995

⁵⁹ Jordan J, Gurr E and Tinline G (Robertson Cooper Ltd.), Giga S, Faragher B and Cooper C (UMIST) for HSE. *Beacons of excellence in stress prevention*. Health and Safety Executive Report: RR133, HSE Books 2003

Individual worker-focused interventions typically involve techniques such as cognitive reappraisal, relaxation guidance, education about exercise and nutrition, and training in developing coping skills. Such approaches have been shown to result in short term improvements in the levels of stress experienced by employees⁶⁰, but have been criticised for wrongly laying responsibility for preventing and treating stress with the individual, rather than requiring employers and organisations to take action to prevent their workplaces from being stress-provoking environments for their employees. In the long term, if work-related stress is to be controlled, it is not enough to equip individual workers with the techniques with which to deal with potentially stressful situations; it is also necessary to bring about fundamental changes to the organisation to try to diminish the stress-inducing aspects of the job, and to address the sources of work stress that are located in the culture and climate of the organisation.⁶¹

This idea has led to the development of the notion of the 'healthy organisation', characterised as one that manages to balance the needs and demands of all stakeholders – consumers, shareholders, employees, government and society.⁶² A healthy organisation is one in which responsibility for reducing stress is attributed to the organisation, and where individual workers are given more responsibilities in terms of active participation in managing change and job redesign, engaging in honest feedback and communication with their employers, and understanding the constraints which operate on the organisation.

Healthy organisations have been defined as those organisations which match jobs to their workers' expertise and needs, effectively manage and reward performance, inform and involve employees in change and decision-making, and support the family and domestic

⁶⁰ Ganster D, *Interventions for building healthy organisations: Suggestions from the stress research literature*. In Murphy L, Hurrell J, Sauter S & Keita G (Eds.), *Job Stress Interventions*. Washington, DC: American Psychological Association, 1995

⁶¹ Schurman S and Israel B, 'Redesigning work systems to reduce stress: A participatory action research approach to creating change' in Murphy L, Hurrell J, S, 1995

⁶² Beer M, Eisenstat R A and Spector B, *The Critical Path for Corporate Renewal*, Harvard Business School Press, 1990

needs of workers.⁶³ The fundamental ideals behind the concept of the healthy organisation thus require a redefinition and clarification of the relationships between workers and organisations, allowing for greater communication and worker participation, and recognition of the unique needs of each individual.⁶⁴

Although there is evidence to suggest that primary interventions at the organisational level can be effective in reducing stress, it seems likely that for such strategies to be truly successful a broader change at the cultural level is required, which is difficult to implement and sustain. Because of the inherent variation of work stress, applying and enforcing blanket legislation can be problematic. Biersner⁶⁵ recommends that with respect to those workplace conditions that are well documented and widely accepted as potential stressors – such as shift work or repetitive activities – specific occupational health and safety standards should be introduced. Such standards would be relatively easily enforced. They would also enable organisations to implement the changes necessary to meet their targets and to monitor their performance.

6.1.2 Secondary stress management strategies

Secondary intervention techniques involve those approaches which aim to treat or mediate the effects of a dysfunction or problem experienced by the individual worker. Typically, such strategies entail intervention by doctors, psychologists or counsellors, and there is frequently disagreement between the various providers of this level of management as to how best to deal with work-related stress.

⁶³ Jamison D and O'Mara J, *Managing the Workforce*, Jossey-Bass, 1991

⁶⁴ Jaffe DT, 'The Healthy Company; Research Paradigms for Personal and Organisation Health' in *Organisation Risk Factors for Stress* (eds) Sauter S L and Murphy L R, American Psychological Association, Washington DC, pp 13- 39, 1995

⁶⁵ Biersner R, 'Developing an occupational stress standard: Rule-making Pitfalls' in Murphy L, Hurrell J, Sauter S and Keita G (Eds), *Job Stress Interventions*, American Psychological Association, 1995

Box 3: Primary intervention strategies: Case studies

Abbey National

As part of its 'Great Place to Work' initiative, the Abbey National has introduced several stress prevention measures that constitute a systematic approach to primary stress prevention. This reflects the company's recognition that staff working in retail banking will frequently have to deal with difficult customers, either in person or in a call centre environment, and that in such situations it can be beneficial to introduce primary level work stress interventions.

Practical measures implemented to reduce stress levels include the introduction of a 'Respite Room' into call centres, which is a dedicated work-free space where employees can leave their office environment and relax after having taken a particularly challenging call. Respite Rooms sometimes take the form of a cyber café where workers can access the internet or play computer games, and can be used by employees during their breaks as well as before and after work. If the Respite Room is used by a member of staff following a particularly difficult call, their line manager is informed so that if needed, the worker will be offered additional support.

Changes have also been introduced to employees' work stations and to the IT system, giving staff more physical space in which to work as well as allowing easier access to sources of information. This has reduced the amount of stress caused by uncomfortable working conditions and complicated technology.

London Electricity

London Electricity has implemented a primary stress intervention strategy called 'Work-Life Solutions', which is an initiative designed to assist employees in achieving a healthy work-life balance. It offers increased flexibility for those employees whose lifestyle or domestic arrangements make working the traditional nine to five day difficult, which is beneficial not only for the members of staff who are able to balance work with their other demands, but also for the organisation, which retains trained staff who might otherwise have been unable to remain at work.

The 'Work-Life Solutions' programme offers measures whereby employees can work flexibly in accordance with both their own needs, and the needs of London Electricity. Options available include part-time work, working from home, job sharing, term-time only work and a number of other flexible working provisions. Employees who wish to take advantage of these provisions must apply to their manager, who then makes a decision on the appropriateness of the policy in the specific case based upon the requirements of the worker, as well as those of the business and other employees.

Source: Jordan et al 2003/HSE

For the worker suffering from the ill effects of stress, the first point of treatment is typically their general practitioner, who is frequently the main or only provider of treatment for the duration of the worker's experience of stress. GPs usually do not have any specialist expertise or knowledge in the area of occupational health, and therefore can prescribe treatments or courses of action that in the long term may prove detrimental to the worker's recovery and delay their return to work. For example, doctors commonly suggest workers take long periods of rest from work in order to recuperate, which may have the effect of making the eventual return to work more difficult, and reinforcing the 'sick role' in the worker's mind.

Toohy⁶⁶ argues that the medicalisation of stress can delay recovery and the return to work by transferring power from the worker and the employer to the medical practitioner, who is given control over the methods and timescale by which the worker will return to health. This can foster dependency of the patient on the doctor and prevent the worker from taking responsibility for their own recovery as they have been defined as 'sick'. Doctors often prescribe medication as a form of stress management, which may ameliorate the problem in the short term, but can have negative consequences if the medication is habit or dependency forming.

On occasion doctors may refer workers suffering from occupational stress to more specialist providers of treatment, such as psychologists, psychiatrists or counsellors. There are varying methods that such specialists can adopt and there is no standardised approach to treatment. However, evidence suggests that cognitive-behavioural treatment is the most effective for dealing with psychological disorders such as anxiety and depression.⁶⁷

⁶⁶ Toohy J, 'Managing the stress phenomenon at work' in Cotton P (Ed.), *Psychological Health in the Workplace: Understanding and Managing Occupational Stress*, The Australian Psychological Society, 1995

⁶⁷ Clark D M, Salkovskis P M, Hackmann A, Wells A, Ludgate J, Gelder M, Brief cognitive therapy for panic disorder: A randomised controlled trial, *Journal of Consulting and Clinical Psychology*, 67 (4), 583-589, 1999

Cognitive-behavioural treatments are frequently favoured as they are seen to produce the quickest and most reliable outcomes for minimal expense.⁶⁸ Such approaches encourage the individual affected to become actively involved in their recovery by equipping them with the behavioural and the cognitive skills required to address the problems they are facing at work. However such techniques are often complicated by the existence of previous mental health problems or an underlying personality disorder which influences and exacerbates their experience of workplace stress; the kind of superficial counselling or psychological help that is offered as a response to occupational stress is typically inadequate to effectively deal with these 'core problems'.⁶⁹

One type of secondary intervention strategy that has become increasingly popular is the Employment Assistance Programme, or EAP, which has been defined as a 'systematic, organised and continuing provision of counselling, advice and assistance, provided by or funded by the employer, designed to help employees...with problems arising from work-related and external sources'.⁷⁰ EAPs offer workers a comprehensive strategy for dealing with a variety of problems including stress management, mental health problems, bereavement and financial and legal worries. Guided by the idea that the individual worker is a whole person affected by a range of concerns and not solely an employee, EAPs provide a combination of proactive strategies for developing coping skills as well as offering professional counselling, and are entirely confidential between the worker and the EAP counsellor, so that the employers are not aware of the issues the worker is experiencing. The research conducted on EAPs so far suggests that when well defined and properly implemented, they can potentially play an important part in the management of work-related stress, although it seems to be the case that the remedies they provide are partial and generalised,

⁶⁸ Peterson A L and Halstead T S, Group cognitive behaviour therapy for depression in a community setting: A clinical replication series, *Behaviour Therapy*, 29, (1), 3-18, 1998

⁶⁹ Cotton P and Jackson H J, *Early Intervention and Prevention in Mental Health*, Victoria: Australian Psychological Society, 1996

⁷⁰ Berridge J, Cooper C L and Highley-Marchington C, *Employee assistance programs and workplace counselling*, Wiley, 1997

rather than generating concrete and precise solutions to specific workplace problems.⁷¹

Box 4: Secondary intervention strategies: Case studies

Leicestershire Department of Planning and Transportation

Within this organisation a course in stress awareness training is conducted by the staff of the Central Occupational Services Department, who are all trained and qualified occupational welfare counsellors with an understanding of the department's key issues. The course enables managers to recognise the causes as well as the symptoms of work-related stress, informs them of their responsibilities for preventing and managing it, and equips them with strategies for preventing and treating stress at work.

AstraZeneca

AstraZeneca have developed a strategy that combines secondary and tertiary interventions, namely, counselling and life management, or the CALM programme. This programme provides staff with health and lifestyle education as well as confidential support to assist them in resolving problems that occur both in and outside of work. Information is made available to employees on a wide range of emotional topics, such as tackling stress, coping with bereavement, dealing with harassment at work, managing anxiety, maintaining close relationships, coping with depression and dealing with family problems.

Source: Jordan et al/ HSE

6.1.3 Tertiary stress management strategies

Tertiary approaches to the management of occupational stress are those which occur after the worker has been diagnosed as suffering from the ill effects of stress and aim to rehabilitate the individual and assist their return to work. The most commonly adopted tertiary approach is case management, which aims to provide a return to work plan for the individual which is co-ordinated between the different treatment providers, and which is as cost effective as possible. Through the process of case management, the strategy for the individual's treatment and rehabilitation is developed, co-ordinated and monitored. Preferably carried out by a medical practitioner in conjunction with both the worker and the employer, case management aims to achieve a collaboratively reached and

⁷¹ Kendall E, Murphy P, O'Neill V and Bursnell S, *Occupational Stress: Factors that Contribute to its Occurrence and Effective Management - A Report to the Workers' Compensation and Rehabilitation Commission, Western Australia*, Workcover Australia, 2000

agreed upon decision as to the best combination of services and treatment for the individual to assist their return to work.

There are broadly five functions to the process of case management:

1. assessment of the worker's needs
2. planning and setting of goals
3. co-ordination of the required treatment and services to achieve those goals
4. implementation of the plan and linking the worker to the services required
5. monitoring and evaluation of the plan's outcomes and success levels.

However the actual operation of case management techniques will vary according to the understanding, expertise and practice of the case manager. The assessment of need, identification and co-ordination of services and evaluation of outcomes will all be influenced by whether the case is perceived as primarily a medical problem, an insurance claim, or an issue of an absent employee.⁷²

The empirical evidence surrounding the success of case management is inconclusive and suggests that its level of success is closely linked to its adherence in practice to the principles that underpin the idea, namely, ensuring client individuality and participation, cost effective and speedy provision of services, and a co-ordinated and comprehensive approach to rehabilitation. However, these principles are often compromised as a result of the financial and other constraints operating on the organisation, legislative requirements, excessively high caseloads, and inexperienced case managers. If the fundamental principles and functions of the case management process are properly understood and applied, it can operate as a cost effective and reliable method for promoting the individual's return to work.

⁷² Kenny D, 'Stressed organisations and organisations stressors: A systemic analysis of workplace injury', *International Journal of Stress Management*, pp 259-267, 1995

Another form of tertiary intervention in occupational rehabilitation is injury management. This is an active process aiming to minimise the impact of the injury, in this case work-related stress, on the individual worker and their capacity to participate fully at work. Such techniques can be effective in assisting the employee's return to work provided that the intervention occurs at an early stage, and their success relies upon proactive management to encourage the individual to return to work as swiftly as possible. Extended absence from work due to ill-health or injury has detrimental consequences on the person's physical and psychological well-being, such that the longer they are away from work due to ill-health, the more difficult it becomes for them to return. This is especially true in the case of work-related stress, where the relationship between the employer and the employee is vulnerable and fragile. Early tertiary intervention and injury management are likely to result in decreased absenteeism, a minimisation of lost work time, lower worker's compensation and disability costs, and greater productivity, and thus are beneficial for workers, employers and insurers.⁷³

6.2 Focussing on prevention

In practice, stress intervention strategies have tended to focus mainly on secondary and tertiary management techniques, rather than primary approaches which seek to prevent stress from arising. Workplace stress intervention has been far more likely to direct its attention towards reducing the impact of stress on individuals and has commonly failed to take action to reduce the presence of stressors in the working environment. In response to this, the HSE has attempted to shift the emphasis towards more proactive intervention measures under the conviction that intervention strategies taken at the organisational level which aim to analyse and eliminate potential sources of stress are more likely to be successful than those which target only the individual.

In the work that helps to underpin the HSE's management standards approach, Jordan et al have developed a model of good practice in

⁷³ Shrey D E and Lacerete M, *Principles and Practices of Disability Management in Industry*, GR Press, 1995

Box 5: Tertiary intervention strategies: Case studies

London Electricity

London Electricity operates an Employee Support Programme for rehabilitating workers who have been absent due to stress, and which is run by an external network of professional counsellors managed by a clinical psychologist. The employee who is referred to the counselling service is provided with up to seven sessions with the clinical psychologist, who may decide that the problems the individual is experiencing are work-related; if this is the case, a series of 'round table' meetings are organised, involving the employee, the manager, the counsellor and representatives from Occupational Health and Human Resources. Following on from these round table meetings a plan of action is agreed upon to assist the employee to return to work.

Good Hope Hospital

Good Hope Hospital aims to offer a counselling service to its employees that is less like traditional counselling and more like a mentoring or coaching programme, which should equip staff with the skills required to tackle their problems. Individuals with serious stress problems are referred to an external organisational psychologist who provides one-to-one coaching to supply them with the coping skills necessary to return to work and be reintegrated into the workplace. Techniques include the use of a personal effectiveness questionnaire which encourages employees to understand their behaviour and to engage in activities which divert their attention away from their sources of stress.

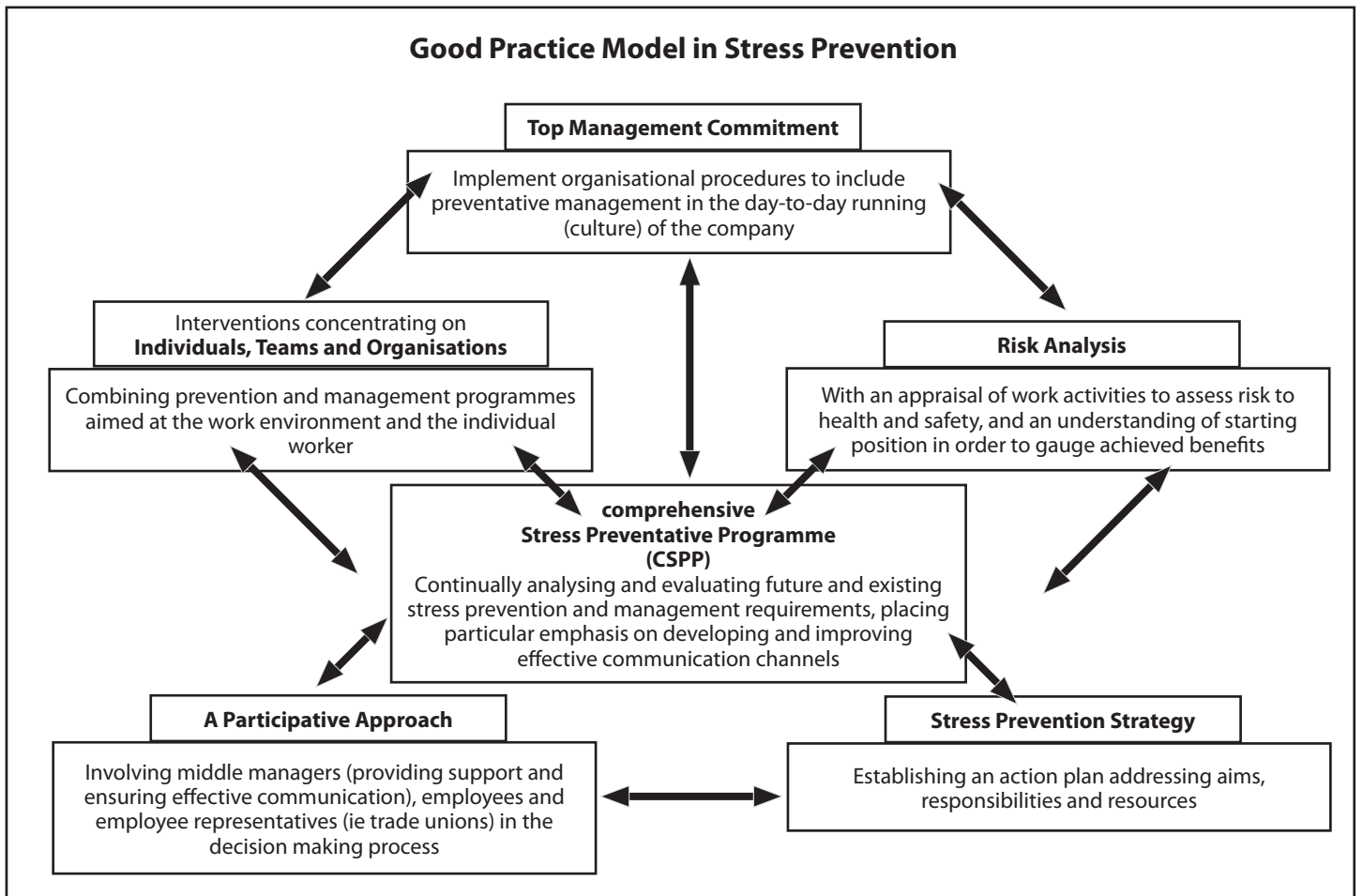
Source: Jordan et al (2003)/ HSE

stress prevention and management (Figure 12), which identifies a number of key elements that are required for any stress management intervention to be successful.⁷⁴ It is intended to be a comprehensive approach to stress prevention and management, which entails both work-related and worker-related strategies and emphasises the necessity for effective communication and collaboration between employees at all levels of the organisation. The different elements of the model are to be thought of as forming essential components of a cyclical process, with the long term aim of improving the practice of stress prevention and management in the workplace.

At the heart of the model is *The Comprehensive Stress Prevention Programme* (CSPP) which should be regarded as an 'all-encompassing organisational philosophy' which is underpinned

⁷⁴ Jordan J, Gurr E and Tinline G (Robertson Cooper Ltd.), Giga S, Faragher B and Cooper C (UMIST) for HSE, *Beacons of excellence in stress prevention*, Health and Safety Executive Report: RR133, HSE Books 2003

Figure 12: Jordan et al model of good practice in stress prevention and management



by the beliefs that the health of the individual and that of the organisation are interdependent and that every member of an organisation should accept responsibility for preventing and managing stress. The assumption is that a programme designed to reduce workplace stress is more likely to be successful when there exists a culture of involvement and inclusion of all employees in the programme's implementation, and where there are high levels of communication and co-operation. The components of the model are:

- senior management commitment
- risk assessment and task analysis
- stress prevention strategy
- a participative approach
- work-related and worker-related prevention and management.

Senior management commitment

For stress prevention programmes to be effectively implemented, it is vital that senior management within the organisation show long term commitment to the programme and its goals. Without the support of senior individuals, any strategy introduced to reduce stress is far less likely to succeed. Senior management will be encouraged to support such programmes if they have a clear understanding of what costs and resources are required, and the expected outcomes and benefits in terms of the performance and productivity of the company.

Within those organisations identified by the HSE as successful at preventing and managing stress – the ‘Beacon’ organisations – most displayed evidence of commitment by top management to stress prevention programmes. This support included not only providing funding for employee health and well-being initiatives, but also personal commitment by senior figures, who frequently took on responsibility for stress prevention in their organisations.

This top management commitment was found to be more prevalent in private sector companies than in public sector organisations. Private sector Beacon candidates tended to have larger infrastructures for health and well-being initiatives, demonstrating greater senior management commitment to provide the investment such schemes require.

Box 6: Case study: GlaxoSmithKline

GlaxoSmithKline's approach to stress prevention is significant as it is characterised by the support and commitment of individuals at the very top levels of the company to employee well-being. Top management shows awareness of the importance of employee health and provides the funding necessary to introduce stress prevention activities.

66 members of staff make up the Employee Health Management Group, which is a part of the Human Resources department that has been given the role of developing standards and strategies for understanding, preventing and managing stress in the workplace. Under the guidance of this body and the Health and Safety department, managers are responsible for implementing employee health and well-being standards, for example the global 'Resilience and Mental Wellbeing' standard, which was introduced with the support of senior officials in the organisation such as the Corporate Executive Team and the Senior Vice President of Human Resources.

Source: Jordan et al/ HSE

Risk assessment and task analysis

If organisations are to identify and reduce work-related stress, it is essential that they gain an understanding of the particular work characteristics and situational factors that may contribute to a stressful environment. Before an appropriate intervention strategy can be developed, it is necessary to carry out an appraisal of work activities which identifies tasks, analyses risks, and assesses any hazards to health and safety which may be inherent in that particular job. Furthermore, this analysis must take the form of a continual, ongoing process which allows intervention strategies to be evaluated and adapted in light of changes that may occur within the organisation. This assessment may make use of data from employee attitude surveys, analysis of absenteeism and sickness rates, and cost/benefit analyses, and will enable the organisation to decide the most appropriate and effective strategy for its own and its workers' needs.

Within the functioning of the Beacon candidates, this process was likely to be well organised and co-ordinated with respect to general health and safety risk; however, methods of assessment

of psychosocial risk tended to be much less well developed. Some organisations carried out few, if any, regular assessments of the psychosocial risks that work carried. Those organisations which did operate a coherent programme of psychosocial risk assessment tended to be those that performed well in other areas of the Good Practice Model. This process of effective risk assessment underpins the other criteria and constitutes a crucial element of any stress management strategy.

Effective procedures for the assessment of psychosocial risk were found to be beneficial not only because they identify the potential stressors of a job and help the organisation devise methods to prevent them, but also because they are usually carried out by experts from outside the team or department, rather than by the manager. Although managers play a central role in implementing stress prevention programmes, if one of the stressors in the workplace is the existence of a poor manager this will be highlighted by the external experts in psychosocial risk, who may be health and safety auditors, occupational health officers, or human resources specialists.

Although all the Beacon organisations demonstrated a coherent approach to assessing health and safety and physical hazards, the Comprehensive Stress Prevention Programme recommends increased co-operation and liaison between health and safety managers trained in traditional assessment of physical risk with specialists of occupational health, HR, and health and well-being.

Stress prevention strategy

A vital component of the Good Practice Model is the formulation by the organisation of a stress prevention strategy – an action plan which details the aims, tasks, resources and responsibilities of the stress management activities and those involved in their implementation. The development process of this strategy should involve managers and employees, so that the plan which results is

Box 7: Case study: Sefton Metropolitan Borough Council

All jobs within Sefton Metropolitan Borough Council currently undergo a stress risk assessment, which is subject to review whenever there is a significant change in the nature of the work. This risk assessment comprises a series of forms which must be completed for each job, and which takes into account all the demands placed upon the holder of the post, both physical and non-physical. The aim of this assessment is to identify all areas of the job which place significant demands upon the worker, to determine the measures which should be put in place both to reduce any unnecessary demands of the role and to assist the employee in coping with those demands that remain.

It is the responsibility of managers to identify psychosocial risk, and they are provided with training on how to do this as well as how to complete the assessment forms. Managers are encouraged to include employees in discussion about the stress risks involved in their posts.

This process of risk assessment operates on several levels within the Council. Managers have responsibility for determining potential stressors and psychosocial problems that exist within the work under their own control. If it is suspected that excess pressure is arising as a result of a manager, then the Health Unit may intervene and conduct its own separate risk assessment. There are also a number of monitoring activities which take place to identify any areas of potential concern, such as analysis of levels of sickness absence and referral to Occupational Health, and monitoring visits to sites of work.

Source: Jordan et al/ HSE

sensitive to the needs, abilities and requirements of all members of the organisation. Managers should have a clear understanding of their role in promoting the health and well-being of their workers, and of the need for effective and continual communication.

As this is an ideal model, few of the Beacon organisations displayed such a coherent and co-ordinated strategy to stress prevention. It requires the collaboration of multiple individuals and departments and co-ordination of various activities. Few organisations operated with a clear plan of action stating the measures that were being undertaken, their rationales and expected benefits. The reason for this may be because many of the stress intervention techniques utilised by the organisations fall into the domains of disparate departments and remits, such as Occupational Health, HR, Health and Safety or Corporate Communications.

Those Beacon candidates which adopted a co-ordinated approach making use of expertise in the three key areas – Occupational Health, HR and Health and Safety – were far more likely to exhibit a coherent stress prevention strategy than those wherein stress prevention was considered to be the responsibility of only one of these fields. This element of the model is also closely associated with the presence of senior management commitment; strategies tended to be clearer and more effective when top management figures were involved in their formulation.

Box 8: Case study: Stockton Borough Council

Stockton Borough Council's approach to stress management is significant due to its utilisation of external expert guidance. Staff from a range of different council services – including Human Resource advisors, Occupational Health professionals, Health and Safety Officers, Health Promotion advisors and Trade Union Representatives – make up Stockton's Employee Care Group, which plays a central role in formulating and implementing policy on work-related stress. In particular, this group has introduced the Employee Care strategy, including stress awareness training, and a stress management policy named 'Coping with Pressure in the Workplace' which has been in place since September 1999.

The Employee Care strategy is modelled on the idea of a 'partnership' between the Council and the Tees and District Health Promotion Service, drawing on expertise from the health service to promote employee wellbeing. The Council has recently been awarded a 'Partners in Health Award' in recognition of its positive commitment towards promoting health in the workplace.

Source: Jordan et al/HSE

A participative approach

Employee participation in all areas of the process is a vital element of the Comprehensive Stress Prevention Programme. Workers at all levels of the organisation should be involved in every stage of the stress prevention strategy, from assessing and diagnosing risk, to deciding upon the appropriate intervention initiative, to evaluating its success. Employees and managers are to be encouraged to participate, with external researchers and consultants facilitating and evaluating the procedure. This inclusion and empowerment of workers significantly increases the programme's chances of achieving a positive outcome.

Beacon candidate organisations adopted this participative approach through a number of practical measures, including undertaking employee surveys, running stress focus groups, and conducting regular appraisals wherein workers could raise issues of stress. In particular, stress awareness training for managers was utilised by all Beacon organisations, and represents a vital component of any stress prevention programme. There is also much evidence of organisations expending large amounts of time, energy and resources gathering information about their employees' attitudes and experiences through the use of surveys; however, it is less clear whether this information was effectively used to develop targeted stress prevention policy and practice.

Box 9: Case study: The Royal and Sun Alliance

The Royal and Sun Alliance undertakes an annual UK-wide survey of their employees which covers a range of issues, including perceptions of pressure in the workplace and their interpretations of potential stressors of their job. This survey has a very high response rate among employees – 85 per cent in the 2001 survey – which provides the organisation with a large body of evidence about how stressful employees perceive their jobs to be, and what the implications of their work is on their health and wellbeing.

Stress-related questions on the survey include whether employees understand the responsibilities of their post and the results they are expected to achieve, whether they feel they have the necessary skills, information and authority to carry out their job, and whether they believe the communication and feedback they receive is satisfactory. Managers are given the results of the survey which are relevant to their section of the business and relate these back to their teams. It is then expected that managers will work in conjunction with the employees to develop a plan of action to address the issues and problems that have been highlighted by the results of the survey.

Source: Jordan et al/ HSE

Conclusion

As a word, stress has a dubious yet undeniable meaning. As a problem, it is extraordinarily widespread and may now have assumed what can only be described as epidemic proportions. In everyday language, policy circles and across the social sciences, stress continues to demand attention. Workplace stress is costly and becoming more so. It has many causes, and these involve complex combinations of physical, social and psychological elements. Stress affects people differently, is difficult to measure and has a fraught relationship with both ill-health and unhappiness. In addition, just as resources are being directed at it, there remain widespread concerns about the precise nature of stress and what it says about contemporary society and workplace practices.

Despite these searching and inconclusive debates, suffering is real and people continue to adopt the affective language of stress to describe (and experience) problems in their work. No matter what its precise nature, stress now places significant pressures on organisations to develop methods for its effective prevention and management. So are policy initiatives underway and laws being written to further establish and institutionalise the discourse of stress, to increase employer responsibility, to develop new interventions and to empower its many victims?

Amongst all this activity, however, there is a lingering doubt that the Emperor is not; in fact, wearing any clothes at all. It is likely that this doubt will continue, even as it becomes increasingly irrelevant to the pressing requirements of organisational practice.

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