Project Title

Impact of Changing Social Structures on Stress and Quality of Life: Individual and Social Perspectives

Project Acronym/Logo

STRESS IMPACT

Work Package 6

Professional Study: Austria

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Vienna, November 2004 *The Authors*

Abbreviations

GM	General Manager
GP	General Practitioner
HSR	Health and Safety Representative
HRM	Human Resource Manager
LTA	Long-term absence, long-term absentee(ism)
MHP	Mental Health Practitioner
RTW	Return to Work (specialist)

Section 1: Overview and Commentary on the Professional Study

1.1 Overview

One main objective of the Stress Impact Project – *Impact of Changing Social Structures on Stress and Quality of Life: Individual and Social Perspectives* – is to explore the relationship between the institutional approach to stress as reflected in current professional practice and work absence and resumption. It was therefore aimed to document current practices of professionals and interventions that have been initiated with respect to work resumption of people who were absent from work due to stress related conditions.

Thus, the professional study is providing a detailed account of professionals' opinion on the subject of long-term sickness absence. And the results are to provide the basis for a theory of long-term sickness absence and, in addition, it is a source for a major input in the development of policies and guidelines for professionals.

Following that, the methodology of the professional study was therefore to interview professionals who deal with stress related sickness absence either in the workplace or at community level, professionals who have experiences with people long-term absent from work in and due to a stress related condition. The Stress Impact Consortium defined types of professionals including General Practitioners, Health and Safety Professionals, General Managers, Human Resource Managers, Mental Health Professionals and Return to Work Specialists.

A standard interview schedule was developed and was used in all interviews and was supplemented with specific questions for the various professions.[1] The interviews guides were semi-structured[2] to allow comparison across professions within and between countries, and were conducted via telephone.[3] The topics involved are the experience in diagnosing stress, the background experience and knowledge requirements of professionals, some case studies about stress-related long-term absentees, factors relating to stress, treatments and interventions, referrals to other professionals in the field, and return to work themes.

[1] The interview guides were composed in English. For conducting the interviews in Austria it was necessary to translate them into German.

[2] A combination of tick boxes and open ended questions was used in the interview guides, so that a combination of qualitative and quantitative analyses could be conducted.

[3] To ensure the quality of the instrument, several pre-tests with selected professionals were made, two per country. Experiences and problems arising were deduced from them and proposed in adaptations. Some of the adaptations have been implemented into the interview guides.

To find interview partners, firstly, potential professionals were localised by several sources, e.g. public electronic telephone book, several internet sources, and individual networks. Then, interview partners were recruited by asking for participation in the study and by giving basic information of the study. If they wanted to participate, a date and time point for the interview was arranged. In sum, 40 interviews were conducted[4], well distributed across all types of professionals, i.e. approximately seven interviews per professional category.[5]

The total sample distribution is listed below and is presented including several breaks: professional category, gender, region, and sector.

Table 1: Description of the Sample of the Professional Study[6]

Variable	Label	Number	In percent
Total number of interviews		N=40	100,0%
Professional Category[1]	*GP*	7	17,5%
	HSR	6	15,0%
	GM	7	17,5%
	HRM	6	15,0%
	MHP	8	20,0%
	RTW	6	15,0%
Gender	*Male*	14	35,0%
	Female	26	65,0%
Region	*Vienna*	26	65,0%
	Other Region	14	35,0%
Sector[2]	*Private*	10	56,0%
	Public	4	22,0%
	Non-profit	4	22,0%

Source: FRK 2004

Annotations:
The minimum work experience of the interviewed professionals is one, the highest is 28 years. The sample distribution of work experience has an arithmetic mean of 11 years of work experience and a median of 10 (standard deviation of 6,89).
[1] GP – General Practitioners, HSR – Health & Safety Representatives, GM – General Managers, HRM – Human Resource Managers, MHP – Mental Health Professionals, RTW – Return to Work Specialists
[2] Comprises only HSR, GM, HRM

[4] For the realisation of the interviews, four interviewers were trained in a workshop. The workshop was about empirical social research, types of survey designs, (telephone) interview methods and interviewing experts, response errors with the main focus on telephone designs.
[5] After the end of each interview, the interviewers transcribed the notes into an electronic format.
[6] In sum 40 interviews with several professionals from different professional categories were conducted. In the mean each interview took 41 minutes of time (median 40 minutes), the shortest interview was 30 and the longest interview was approximately 60 minutes (standard deviation: 8,86 minutes).

1.2 Commentaries

In general, the effectiveness of the steps described, from the research questions to this report, was very good. The study was coordinated by representatives of the University Centre for Disability Studies[7] (UCD) which means that they proposed characteristics of the study design and these where discussed by all partners of the project at project meetings or via e-mail. After the decisions in the consortium, each partner including Austria had to "translate" the study characteristics to the national level. This procedure was very helpful for the success of the study. Nevertheless, the study has its limitations.

Some methodological aspects first: After the types of professionals were defined, we had to find groups of professionals who are falling into these types. It seems strange that we mention this now and it was surprising for us that problems arose. There were no problems in finding General Practitioners, General Managers, and Human Resource Managers. But it was problematic to find appropriate Return to Work specialists. The simple reason is that professionals are very inhomogeneous across countries and this sometimes makes international research challenging. Some redefinitions were made and we think that a satisfactory approach was found. In the sample there are now one social worker, one case manager, one occupational rehabilitation manager, and three project managers whereby the specific projects are targeting different groups (i.e. long-term unemployed people, people with mental disorders).

It is nothing new that translations of research instruments can be difficult. We needed a lot of time and experts' know how for that.[8] Additionally, it was also a good process for all partners since they had to find equivalent expressions in their own language and the reflection about these improved the final versions of the interview guides significantly.

The interviewee recruitment was challenging. After the consortium decision we sent out about 150 letters to professionals with the aim to get approximately 40 positive participation agreements. In fact we got eight positive feed-backs only. So, we had to change our strategy to get the remaining 32 professionals. We started another recruitment phase and achieved the remaining participations by calling them directly or using some snowball sampling[9].

[7] Special thanks to our UCD partners Donal McAnaney and Julie Thorne.
[8] Many thanks for the translation work and editorial sessions with Barbara Reiterer.
[9] We called some experts of our professional network and asked them whether they knew experts who are falling into our types/categories of professionals. If so, we asked for the name, profession, and telephone number to try to recruit them for the study.

It is also worth mentioning that our three interviewers did exceptionally good work. The Austrian team has seen very early that it is inevitable to perform training courses for the process of the interview. It was useful that all of them have a different background but to bring all on the same level trainings were necessary. At the end, each interviewer interviewed two categories of professionals that mean that we could have some interviewer effects within the groups of professionals. For several reasons, we decided to go this way since we tried to bring the background of the interviewers with the type of professionals (e.g. a physician interviewed the health professionals).[10]

During the interviews the interviewer had to take notes of the answers of the professionals. Because it was designed as a telephone interview it was sometimes difficult to write up all in very short time. The interviewees were very insightful with this fact and most of the interview partners also accepted the resulting gaps between the questions. Basically we had no problems with the lengths of the interviews. The shortest interview took 30 and the longest about 60 minutes. In the mean we exactly hit the previous communicated interview length of 40 minutes per interview.

Nevertheless, it is been expected that the results would give many valuable insights in professionals' perceptions and experiences.

Last but not least we want to make some remarks about the applied methodology. In the universe of empirical research methods the professional study in the Stress Impact project is a survey design, conducted via telephone (telephone survey design), where experts have been interviewed (expert interviews). The sample of experts is a judgement sample. The sample is not representative since we were more interested in professionals' awareness and experiences with people long-term absent from work due to stress related reasons than in representativeness.

The level of structuring of the interview guides can be called semi-structured because there were realised, closed and open ended questions as well. Closed questions were used because we wanted to ensure objectivity, reliability and validity of the data. In the interview guide there were also open ended questions to get qualitative data and therefore a broader spectrum of the topics. The resulting data should have high quality due to the fact that we performed latest research design claims.

This report of the professional study of the Stress Impact Project gives the reader an overview of the main results in Austria. Chapter 2 describes issues and trends that arose within each

[10] We also say thank you to Christina Reichelt, Nicole Tomisser, and Bernhard Roessler. Each of them was also involved in writing this report.

category of professional and some illustrations from case studies. A description by themes, differences and similarities between types of professionals, is provided in chapter 3. The report presents some discussion points (chapter 4) and closes with conclusions and recommendations (chapter 5). In addition to the text, the annexes provide an anonymous summary of profiles by category and an overview of professionals' roles and responsibilities.

Section 2: Description of Types of Professionals

2.1 Issues and Trends of each Type of Professional

2.1.1 Incidents of Stress and related Complaints

One of the opening questions of the interview of each professional category was the perception of the incidents of stress. The interviewee was forced to estimate the incidents of stress in the workplace, whether it had increased, decreased, or stayed the same.[11]

Most of the interviewed *Health and Safety Representatives* (HSR) perceived an increase of work related stress, only one person gave the answer "stayed the same", and one had no idea ("don't know"). Nobody of the interviewed HSRs said that the incidence of stress at the workplace had decreased over the past five years. More or less the same picture can be drawn from the results of the interviewed *Human Resource Managers* (HRM). Nobody observed a decrease in occupational stress, whereas 4 of 6 persons responded an increase of stress at the workplace and 2 estimated the same as five years ago. And nearly all of the *General Managers* (GM) stated an increase (6 of 7 persons) and only one interview partner answered to the question with no change compared to the situation five years ago. Last but not least the interviewed *Return to Work Specialists* (RTW) gave us the same impression. 4 of 6 RTW Specialists stated an increase and the other two specialists responded us with "stayed the same" or "don't know".

The incident of stress was also surveyed from the perspective of *General Practitioners* (GP) and from *Mental Health Professionals* (MHP). The interview question was: "*Has the frequency with which your patients refer to stress in describing their condition increased/decreased or stayed the same over the past five years?*"

A same conclusion can be drawn from the interviewed medical professions. Nearly all of the GPs and MHPs stated an increase of stress in their client base. Only one GP and one MHP declared that the incident of stress stayed the same over the years and only one MHP couldn't answer the question ("don't know"). None of the GPs or MHPs perceived a decrease of the frequency of stress in their patients.

[11] This question was only asked to professionals who are dealing with the workforce.

2.1.2 Reasons of Increase or Decrease of Stress

The interviewees were also asked to confirm their statement concerning the perceived change of stress (in the workplace or in the client base) and they were asked to explain why this is the case.

Many of the *GPs* mentioned that the increase results from changed employment and work related conditions: pressure to perform, quantitative and qualitative demands; labour market situation (high unemployment, reduction of labour force); fear of dismissals, etc. Also problems in personal relationships occur more often and the possibility to talk about it, cultural changes (i.e. "younger, faster, etc."), and living conditions were pointed out by GPs without further specification.

HSR professionals constituted the increase of stress in the workplace basing on two stages, the economic situation and its impact on the companies and the individuals as well. They state higher economic pressure for the companies, higher demands for companies and they have more pressure to succeed. This change also had an impact on the manpower within these companies under pressure. As a consequence, employees stress was increasing.

GMs also mentioned the change of the economic and the global business which has an enormous effect on the companies. To survive in the global market it is essential to be better and faster than the others; the demands, the content and the time pressure of work is higher nowadays; change of personality of the managers; staff reduction and simultaneous increase of aims; dynamic and faster business life and the necessity of quicker means of communication (mobile phones, fax, e-mail, etc.).

The interviewed *HRMs* saw the increase of stress in the workplace based on internal and external factors. The external factors were high pressure of the economic change (e.g. in emerging markets), higher competition, etc. Internal factors were the pressures on prices, reorganisations of companies, staff rotation, level of effort etc. that were are causing stress on an individual level.

The MHPs mentioned the changed society as the reason of the increase of stress. They elaborated the societal transformation because of economic and labour situation (e.g. the pressure at work place and on the labour market). Everybody must be "(…) *schneller, schoener und besser*" (E3, p. 1).[12] The pressure of labour (e.g. job dismissals, unemployment) and the financial risks are higher now. Employees must be more flexible and further education

[12] Translation: "Much faster, more beautiful and better."

is claimed by the employer. Because of these changes, the compensation of the enormous pressure is more difficult for everybody and the consequence is the increase of stress.

RTWs explained the increase based on the higher pressure and concurrence and because the expectations on the individuals is higher now (e.g. higher qualification levels and more effort are claimed). The companies reduce their staff and the unemployment is rising. The consequence is that "(...) *immer weniger Leute immer mehr Arbeit verrichten*" (RTW1, p. 1)[13].

2.1.3 Models of Stress adopted

Professionals were also asked about their models of stress, and how they would describe it. Descriptions and definitions of stress can be divided into categories of stress: causes, characteristics, and manifestations.

The interviewed GPs described stress with characteristics and manifestations. In their view stress can be described as overload, excessive demands, and situations of pressure, restriction, and *demands such as environment, conflicts, and pain.* (GP1, p. 1) They also differentiated between the positive form of stress, eustress (e.g. positive, tension; a longer time period of unchangeable dissatisfaction, etc.), and the negative form, distress (e.g. negative, high frustration, overload, high demands). One GP specified a long list of diagnoses which could be combined with or caused by stress (e.g. high blood pressure, stomach ulcer, headache, sleep disturbance, restlessness, burnout, social isolation, mobbing, and abjection).

The answers of the HSRs showed two main causes and characteristics of stress. On the one hand stress is the feeling of impossibility to cope with the demands in a defined time period.[14] Another representative of this professional category also mentioned this in combination with the contradictoriness between family and work.[15] On the other hand, the HSR mentioned that stress is caused by the prevalence of strain and demands which are not compensated adequately for, e.g. by recovery phases.[16]

GMs defined and described stress more or less with personal overload, too many orders and demands in a specific and short time period (e.g. work and time pressure), unclear inputs and guidelines, tasks to solve or to deal with under time pressure with the aim of efficiency

[13] Translation: "The less people are working more and more."
[14] "*Stress ist das Gefuehl, mit den Aufgaben zeitlich nicht fertig zu werden.*" (HSR1, p. 1)
[15] „(...) *zuviel Arbeit, zu wenig Zeit; nicht vereinbaren koennen mit Familie und Beruf.*" (HSR3, p. 13)
[16] „(...) *entsteht durch Anforderungen, wenn die Erholungsphasen und Kompensationsmechanismen nicht mehr ausreichen.*" (HSR5, p. 25); „(...) *Ueberhandnehmen von Belastungen.*" (HSR4, p. 19)

and without mistakes. One GP also described stress as a feeling of unfinished tasks or the feeling of not knowing how to solve a problem, not knowing how to complete the work.[17] Following this description, stress is not only caused by the quantity of work.

One interviewee of the category HRM mentioned that stress is given when one doesn't know who to manage the present tasks. Other interview partners also mentioned the time pressure, deadline constraints and too many tasks to do with too little resources and in the long run with consequences for ill health. An interviewee described stress simply as "(…) *aus der Balance geraten*" (HRM4, p. 1)[18]

An interviewed MHP gave us a very homogeneous picture of descriptions of stress. More or less everybody of our interviewee's defined stress in a similar way. In their point of view, stress is strain over a longer period of time without adequate relaxation phases. Stress occurs when somebody needs an adaptation of the demands und mobilisation of resources in a specific situation. Therefore, stress is defined as a physical and mental overload, an imbalance between tension and relaxation; A overstretch of the needed possibilities (of the mental possibilities) to cope with the every day problems. Nervousness, hypertension, anxiety, sleep disturbances, feeling of unhappiness are examples of the stress results.

RTW specialists also described stress as time and work pressure, excessive demands in every day life, the feeling of *haven't done or finished anything* (RTW2, p. 1) or the combination of tasks to solve urgently with too little time resources. Some RTW specialists also defined stress with somatic and psychosomatic consequences.

HSRs, GMs and HRMs were also asked for the company they are working for and whether they use a specific definition of stress. In general we can conclude that from 19 interviews with representatives from these three categories of professionals, only three interviewees told us, that their company is using a definition (none of the HSR, 2 GMs, and 1 HRM). Only one of the three could describe the definition[19]: "*Stress means to work under pressure, with many deadlines, means strain and work pressure.*" (GM3, p. 1)

[17] „*Stress ist das Gefuehl, etwas nicht erledigt zu haben bzw. nicht zu wissen, wie etwas zu erledigen ist oder wie man zur Loesung oder zum Ziel kommt.*" (GM7, p. 43)
[18] Translation: "To lose one's balance."
[19] The others don't know the definition for stress.

2.1.4 Experiences in Stress Recognition

On the question "*How do you go about diagnosing stress?*" GPs reported that they search for the causes of stress together with the patient preliminary (e.g. talk about the stressors in life; anamnesis, self-observation, questionnaire about stress). After that the resources of the patient are also evaluated then they provide a method of resolution or an intervention strategy (e.g. relaxation therapy). If a patient presents another, non-stress condition which might also be stress related all of the seven GPs reported that they normally investigate further. Then they try to explore further or they examine more in detail and if they can't help they refer the patient to another professional.

But for which and to what extent do GPs think that stress is the cause for conditions?

Most of the GPs, 5 of 7 interviewees, indicated by their answers that that cardiovascular problems and mental disorders are an important factor causing stress. On the second place, 4 GPs said that musculoskeletal problems, respiratory problems and tumours/cancer are also to a great extent caused by stress. Many GPs answered "to some extent" are digestive problems, injuries from accidents, endocrine and metabolic diseases and 3 said genitourinary and skin problems the source of stress related conditions. Blood diseases were not seen as a source of stress by the majority of GPs.

Another question was about the experience in diagnosing stress. GPs were prompted with a list of diagnoses and the professions were treated to indicate which of them and how often they use those. GPs used backache and depression most frequently from the prompted list of diagnostic labels (5 of 7 GPs diagnoses them very often). Four of the interviewed GPs also used fatigue or TATT[20] very often and three of them used anxiety and stress frequently. Burn-out as diagnosis only was mentioned by 2 as a very frequently used diagnosis within their client base and by 3 sometimes. Concerning the most frequently used diagnoses GPs mentioned physical overload, work and family strain and critical life-events as the main reasons for stress related conditions.

Important information about the causal factors of stress was also provided by the GPs. In their experience cardiovascular problems, mental disorders, musculoskeletal problems, respiratory problems, and tumours/cancer are to a great extent caused by stress. The majority of GPs observe within their client base that injuries from accidents neurological and sensory

[20] TATT stands for "Tired All The Time"

problems, genitourinary problems, skin problems, and endocrine and metabolic diseases are to some extent the cause of stress.

The interviewed GPs estimated the percentage of their patients which are primarily diagnosed of stress related condition between 25 and 70%. The MHPs reported that the most common diagnosis amongst their client group is depression and they estimated that between 20 and 60% of their clients are primary diagnosed with a stress related condition.[21] And last but not least the RTW specialists reported – given the same question – that they estimate a percentage between 1 and 60%.[22]

2.1.5 Problems and Reservations in identifying Stress

The GPs didn't reported any reservations in using the diagnosis of stress related condition and also nearly all of the interviewed GPs said that they also had no problems when diagnosing stress in the patient. The only problem that could arise was that the patients ignored and negated their own stress condition. Another GP also reported that *it is trendy to have stress* but only in the case when patients have the complete control of the stressful situations.

Professionals who have contact with employees, HSRs, GMs, and HRMs were asked about their recognition of stress and stress related conditions. All interviewed professionals of the three categories already had contact with cases of stress in their employees. All HSR reported that they had contact with employees about the issue of stress and all of them brought the issue of stress to the attention within the organisation they are working for (e.g. Human Resource Officer, Occupational Health Officer, etc.). Also all GMs and also all of the interviewed HRMs told our interviewers that they (already) had encountered stress in employees within the organisation.

But what signals did they use to recognise stress?

When HSRs talk about the employees they can recognise stress frequently. They often found strain when they spoke about their daily work life and could identify stress on the typical complaints (e.g. high blood pressure, panic, stomach trouble, tachycardia, musculoskeletal problems or tension) or when they reported about symptoms where the employee had no explanation. GMs and HRMs recognised stress because of emotional and physical reactions of the employees. Then employees were often nervous, strained, tensed,

[21] *From where the clients with stress related conditions referred to MHPs by?* 6 stated "self referrals" and 5 of 8 MHPs stated "GPs/Medical Doctor" respectively "Medical Specialist".
[22] Because the RTW specialists interviewed are a very inhomogeneous group with completely different types of clients, the percentage has this broad range of estimated percentage of stress diagnosis.

overloaded, hectic, demotivated, and not well concentrated. Then the speech and the body language were also different and sometimes the work efficiency and quality broke down rapidly.

2.1.6 Knowledge Requirements of Professionals

Most of the interviewed professionals felt that they had sufficient knowledge and awareness of stress to deal with most situations that arose on behalf of the clients. Across all interviews and categories of professionals only 7 of 40 felt not to have sufficient knowledge and awareness (3 HRMs, 2 HSRs, 1 GM and 1 RTW representative). Main information sources of the professionals were (further) education, training and schoolings; books, journals, newspapers, television, radio, and internet; via congresses and seminars, or simple from conversations or from their own experiences.

Very inhomogeneous were the answers to the question whether or not the professionals needed more information about particular areas of stress. 4 of 7 GPs and 5 of 6 HRMs needed no more information about stress whereas 5 of 8 MHPs told that they did (the other professional groups were divided 50:50 equally). These particular areas of stress, fields of stress where they think that they need more information were: causes of stress; group conflicts; burnout and mobbing; posttraumatic stress; the relationship between age, gender, and shift work and stress; relationship between strain and physical impacts or between anxiety and panic attacks; time management; work/life or family/work-balance; organizational and jurisdictional boundaries during implementing; and stress coping.

2.1.7 Causal Factors in Stress

When patients and clients talk about stress to the different types of professionals the factor job was most often mentioned across all types of professionals. The answers and therefore the causes of stress account approximately for 60% of all answers given. "*Die* (…) *arbeitsplatzbezogenen Sachen sind am wichtigsten, persoenliche Dinge auch, aber erst in zweiter Linie; finanzielle Probleme stehen oft im Zusammenhang mit beruflichen Problemen.*" (MHP8, p. 3) On the second place were personal, family and relationship causes of stress. These accounted for one fourth of all responses by the professionals. Not often recorded by the interviewers were health and financial problems as causal factors in stress.

Representative statements of the professionals about causal factors of stress concerning job and working conditions were workplace pressure, workload and pace of work, amount of work, lack of time, strict time limits; lack of communication, work climate, problems with co-workers or supervisors, group processes; stress with clients; job dissatisfaction; job strain; job control; lack of individual authority concerning work pace and break; high expectances, mobbing, fear of own failure, fear of job loss; organizational changes, organisation of work; increased flexibility, decision authority/lack of decisions; and other worksite factors (e.g. room, light, air, heat, noise, etc.). A selection of important personal, family factors of stress due to the relationship to other persons were family problems and dissatisfaction; double load, work/family-balance; posttraumatic situations (e.g. divorce or death of partner); lack of family relaxation phases; care for dependents; want of appreciation; social isolation, personal problems, living conditions; low self-esteem, and low feeling of security.

As stated above, the health situation and its changes can also be a causal factor in stress. Respondents gave us some examples when and why this could occur. Examples were the reaction one's own health, specific symptoms, health problems (e.g. which producing sickness absences), musculoskeletal problems, back pain, etc. Additionally, financial problems and liabilities were also stated in this respect.

Furthermore, all professional groups were also asked about causal factors of stress and which are most commonly defined as a cause of stress by the professionals' clients.[23] The results were that the professionals also perceived the job as the most often causal factor in stress. Death/mourning, relationship with partner, loneliness and the clients' health were also most often mentioned in this association. Finances, relatives, and children were most frequently mentioned causing stress "sometimes".

2.1.8 Most frequently mentioned Interventions

The professionals were asked for interventions to prevent employees going out absent on the one hand and usages of treatments in cases of patients with stress related conditions on the other hand. Interventions for employees were only asked to HSRs, GMs and HRMs, professionals who are able to give information concerning occupational matters whereas questions about used treatments were just posed to GPs, MHPs and RTWs.

[23] The interviewer read out/prompted a list and the interviewee rated each item on a scale from "often", "sometimes" to "not at all".

Information/communication (e.g. team incentives, appraisal interview, seminars, and schoolings), health interventions and health promotion (e.g. preventive medical checkups, inoculation programs, jogging, chi-gong and yoga, football, bowling) and organizational/work adaptations (e.g. offer of part-time employment, good climate, management culture, mutual feed-back, flexitime, arrangements for "healthy" shift-work, flexible time offset) were most frequently mentioned as interventions to prevent employees' absence. Evaluation programs (e.g. checks for safety features and equipment, rooms, noise, computer workplaces), coaching and supervision were also, but not as frequently, stated by the interviewees. No big differences in the answers between the types of professions emerged.

For patients with stress related conditions, GPs, MHPs and RTWs recommended mental health services (e.g. psychotropic drugs such as anti-anxiety, tranquillisers, sleeping pills, anti-depressants, etc.), non-health interventions (e.g. vocational training, occupational rehabilitation, provision of technological aids, worksite adaptations, etc.) and allied health interventions (e.g. physiotherapy, occupational therapy, chiropractic, osteopathy, massage, etc.) most frequently. Whereas allied health interventions were mostly recommended by GPs and MHPs, mental health services by GPs, MHPs and RTW specialists, non-health interventions (e.g. acupuncture, homeopathy, yoga, shiatsu, etc.) by MHPs and RTW specialists, psychiatric interventions and alternative interventions mainly by MHPs. Not very popular and not often recommended treatments were other medical interventions such as painkillers, antibiotics, etc. in our sample of professionals.[24]

2.1.9 Relevance and Effectiveness of Interventions

From the view of the experts, treatments of mental health services are the most effective intervention. 20 of 21 interviewees stated services and interventions, such as counselling, psychotherapy, psychological, and psychoanalysis as good interventions. Alternative interventions, non-health interventions and allied health interventions were also rated as effective interventions by the majority of the experts (17; 17; and 16 of 21 interviews). Whereas most of the interviewed MHPs rated most categories of treatments as effective, there were slight differences between GPs and RTWs. Homogeneous answers of the GPs were observed within the treatments allied health interventions and mental health services (6 and 7

[24] Additionally, some interviewees mentioned, that the establishment of a good communication between client and professional were often used as a necessary first intervention strategy. In some cases they were also in contact and cooperation with, such as liability, alcohol and drug counselling, counselling services for women, and for work/life-balance.

of 7 GPs). A RTW also mentioned, that the mental health services were very effective and also non-health interventions were, too (all 6 of 6 RTW).

"(…) *alles ist nur in Kombination miteinander effektiv.*" (GP1, p. 4) In general, it was stated that only the combination of different types of interventions or treatments is effective but individual adjustment of treatment was needed. Therefore, it is a basic requirement that the patients must be taken seriously, "*Die Grundvoraussetzung ist das Ernstnehmen des Patienten.*" (MHP8, p. 4)

Asked for, frequently used ineffective interventions and treatments for stress related conditions in general were: to set the patient under pressure, ahead of time and one-sided interventions (e.g. only psychotropic drugs), and: "*Gar nichts tun, die Leute in Stich lassen.*"[25] (MHP1, p. 4)

2.1.10 Return to Work Objective

How salient is the return to work objective for interviewed professionals?

Confronted with a patient with a stress related condition, most of the interviewed GPs investigated whether or not the patients were absent from work or not. 6 out of 7 GPs whereas only 2 of 7 MHPs said to do so (one MHP was indifferent). In sum, only half of the interviewed medical professionals examines the status "*work absenteeism*" when they are clients of theirs.

The return to work objective of professionals can also be highlighted in terms of interventions taken. Eight of 15 GPs or MHPs answered that they involve themselves to assist the patients, who were absent from work due to a stress related condition, to return to work. The pattern of the answers of GPs and MHPs was now the other way round: only 2 of 6 GPs (one was indifferent) and whereas 6 of 8 MHPs said that they help them in the return to work process. 4 of 7 GPs supposed that they should be more involved in the process of returning patients with stress related conditions back to work but they also stated problems and provisions. First of all one interviewee mentioned that it was a time problem for GPs in general. They (note: practitioners) "cannot do everything", like one of our interviewees said ("*Was sollen die Praktiker noch alles tun?*", GP4, p. 5) and one said that "it should be but not without being paid" ("*Ja, aber nicht kostenlos.*", GP5, p. 5). One opponent argued that GPs would be swamped with the involvement in the return to work process because they were not

[25] Translation: "*To do nothing, to abandon the patients!*"

educated for this problems ("[…] *weil Allgemeinmediziner damit ueberfordert sind und nicht ausgebildet sind.*" GP7, p. 5).

Professionals who are working for organizations were asked for work arrangements and adaptations with the aim to assist an employee who had been out absent to return to work. From the 19 interviewed (6 HSRs, 7 GMs, 6 HRMs) 17 professionals mentioned that redeployment (i.e. moving to another job within the organisation) was made to support the return to work process for employees. Assistance for employee resumption was also very often made with changed work organisation (e.g. decreased work load) and changed employment conditions (e.g. flexible time) by 14 and 13 interviewees of total 19 professionals respectively. Less often used were individual interventions (e.g. training or retraining, work or job assessment, etc.), provision of technical aids or adaptations, and changed work environment (e.g. improved ergonomics). The differences between the professionals were only minor. Redeployment was most frequently mentioned by all professions, most often by HSRs, GMs and HRMs. Changed work organisation and employment conditions were just as often stated by the three types of professionals.

For "normal" absentees there are in most times no special resumption activities or programs were available. But the established assistance is preliminary the communication with the absentee. That could be a normal dialog or sometimes a discussion, a coaching or sometimes supervision. Some professionals mentioned that the absentee could also get a support to assist the early returnees with additional man power. A type of mentor system was also very often stated were the mentor is helping the returnees. Other professionals also reported that employees, which returned to work, had the possibility to "start slower" and get a secure feeling of the supervisor and security not to fear dismissal. Most of the professionals mentioned, that their organisations normally did not distinguish between those who were absent due to long-term sickness or as a consequence of stress. Usually they told us that no specific program exists and they stated that the organisation react more on an individual level. So, depending on the case of long-term absenteeism, also due to stress related conditions, the interviewed representatives of organisations mentioned some possibilities used in the past: early retirement, individual changes and adaptations of work organisations and employment conditions, part-time employment, disability pension, changed employment contract, etc.

2.1.11 Factors for successful Return to Work

The interviewees reported a lot of successful return to work strategies. By analysing the answers to the question which factors are important to return to work, five main factors have been emerged: occupational, therapeutic and medical, personal and social factors.

Most frequently mentioned were occupational factors that could be applied to help people to return to work. These were the most important statements: new working environment, reduction of working hours, change of workplace situation, worksite adaptations, flexitime; reduction of pressure; supervision and co-worker support, forcing team work; culture of communication and dialog between all hierarchies; coaching, continuous supervision; re-education, further training; information campaigns (e.g. health promotion); time for regeneration, distance from work (e.g. time out, sickness absence); reintegration procedures (e.g. slow-going job reintegration and reemploy warranty).

Mentioned personal factors or characteristics that helped to RTW by the professionals were for instance the understanding of the patient (the patient is not in the position of victimhood any longer); active coping with the situation; financial coverage, strength the awareness, self-esteem, knowledge of relationships, arrange self-management methods, help to structure life (reduction of chaos, restore order); motivation for change, strengthening of personality, and relaxation.

Stated appropriate therapeutic and medical factors for successful RTW were psychotherapy, behavioural group therapy, reflection; medication (e.g. antidepressants); wellness, sport, massages; or simply discussions, medical and psychological information can be helpful for the client. Helpful factors for RTW were also the social support of family and friends and the understanding of colleagues.

2.1.12 Referrals

Asked to whom professionals would refer someone with a stress related condition to generally GPs, HSRs, GMs and HRMs first clarified somatic disorders or referred their clients to a doctor and then to psychological help or coaching. GPs said they frequently referred patients to a counsellor or therapist if psychological help seems adequate (because of the efficiency, more time to talk) and some also to medical specialists (e.g. internists, orthopaedists)

depending which somatic complaints were given. They said they sometimes referred to psychiatrists, rehabilitation centres (in cases of long lasting musculoskeletal problems), some also to physiotherapists (in cases of tension, to work with the body) and community Welfare Officer/Social Workers (because of their social competence). As a last resort, HSR' often refer to psychotherapists and further statements were: family or company doctor, autogenic training, and workers' council. GMs and HRMs refer to a doctor of their confidence (company doctor or family doctor), then they organized psychological counselling and/or coaching. Interestingly GMs did not once say they referred their employees to the human resources department. Whether they preferred to keep things inside the organization (e.g. company doctor) or not (e.g. family doctor, external counselling) differed enormously within the sample of GMs. It seemed to depend on the general working atmosphere and the personal trust. Two HRMs mentioned therefore the "family service", a neutral organization that provides counselling for the employees of its members they had had positive experiences with it. (GM3 and GM4, p. 4)

MHPs and RTWs were asked the other way round: "*From whom were these clients with stress related conditions referred to you by?*" Some took self referral, GPs and medical specialists, few social insurance companies and psychologists. According to the MHPs the most typical reasons given for those referrals were: to clarify the psychological condition (with or without physical disorders diagnosed); depression, social conflicts and suspicion of mobbing, sickness leave, restricted working capacity (to clarify the employability), fatigue, "subjective" burnout; psychological strain, psychiatrists are furthermore asked for medication or a medical diagnosis or expertise. RTWs indicated health and work related problems as well as reasons for referrals.

2.1.13 Steps to Return to Work; Professionals, Family, and Employers

As mentioned above two GPs[26] and all MHPs told us that they were getting involved in assisting people to return to work. Asked to describe the steps they took, they responded us things like "*Das ist ja meine Arbeit.*"[27] (MHP5, p. 5) or „*Die Schritte unternimmt der Patient mit meiner Begleitung.*"[28] (GP6, p. 5) That included psychotherapy (i.e. situation diagnosis, cognitive restructuring, behavioural therapy) as well as help and recommendations (i.e.

[26] Additionally both of them also have a certificate for psychotherapy.
[27] Translation: „Actually that's my work!"
[28] Translation: "The steps take the patient, and I accompany him."

relaxing techniques, advanced vocational training, initiation of talks with the line manager). One interviewee even said he tried to enlarge the time of the sickness leave to allow for enough time for recovery. (MHP7, p. 4)

All work related professionals were asked about the arrangements and adaptations made by the organisation to assist an employee who has been absent from work. The general opinion was that organizational arrangements and adaptations depend on the period of the sickness leave of the absentee. *„Bei kurzen Krankenstaenden: er/sie wird wieder hingesetzt; damit ist die Sache erledigt.“*[29]. (HSR6, p. 4) In cases of long time absence: being assured that the job would be reserved as long as the recovery might take was not perceived as a regular practice (especially talking about other organizations) though it was regarded as very important. Concerning adaptations many interviewees confirmed: changed work organisation like decreasing the work load firstly, so the returnee would not drown in the flood of work (HRM4, p. 5); changed employment conditions e.g. part time or the possibility of telecommuting; job rotation (e.g. shift workers were given another job). Some reported a changed work environment (e.g. improved ergonomics and the provision of technical aids/adaptations). Solely or in addition to “institutionalised” programmes interviewees’ emphasis was laid on individual interventions (e.g. (re)training, feedback talks, coaching or supervision, handing over the work). Some also discussed the reasons for the absence as a basis for further interventions. Some pointed out the need not to challenge the returnee too much (i.e. give enough time, appreciation, the feeling of need) and at the same time not to make him/her feel unchallenged, e.g. “(…) *sie dort abholen, wo sie gerade stehen.*“[30] (HRM4, p. 5) This was even more crucial in cases of disabled or addicted persons (i.e. undergo psychotherapy or join a self-help group/support group parallel to the return to work process.) (RTW6, p. 3)

Should GPs and MHPs get involved in the process of returning patients with stress related conditions back to work? GPs gave us different statements, some said “yes”, some “no”. In the cases of agreement to the question the interviewee mentioned that this (additional) service is time and money consuming. The main argument of disagreeing GPs was that they were not trained for that. The general opinion of MHPs was that they should get involved in the RTW process of their clients/patients. One interviewee assumed that “classic” psychiatrists were not very helpful in this context, they would have to make social work as well (MHP8, p. 5).

In addition, nearly all GPs, MHPs and RTWs questioned answered in an affirmative way that they had involved family members in the recovery or return to work process, namely in

[29] Translation: “In cases of short time sickness leaves: he/she is put into the same position, that’s the end of it”
[30] Means: To take the clients individual situation into account and adjust the interventions accordingly.

form of talks. Some have a systemic approach working with relatives and is part of their concept anyway (in general and particular when dealing with young or addicted people). Some said something like "(...) *wenn das in der Familie Schwierigkeiten macht (z.B. Stress auch in der Familie und nicht nur arbeitsbedingt), dann rede ich mit dem Patienten ueber seine Familie und mit dessen Einverstaendnis auch mit Familienangehoerigen*."[31] (GP7, p. 5) Another interviewee was forced to involve the client's family members because of his/her language difficulties. (RTW3, p. 3) Most involve family members by proposing conversation with significant others (e.g. partner, parents and other relatives with a close relationship to the patient). If the patient was not cooperative, one interviewee stated the strategy to use a one-on-one communication with family members. (RTW2, p. 3) Another one also mentioned interventions not only conversations (RTW6, p. 3). As a purpose of involving the relatives there some provide information (e.g. explaining the disease and its symptoms), include the partners view in the situation analysis, establish understanding and some try to solve potential conflicts, and involve them in planning next steps (where they can be helpful or where they need help respectively).

To the question if they had ever been contacted by a patients/clients employer with regard to returning them to work, half of the professionals (GPs, MHPs and RTWs) answered in an affirmative way. The reasons for making contact with the absentee had a broad range from "*for positive reasons only*" to "(…) *aus 'guten' und auch aus 'boesen' Gruenden*"[32] (MHP8, p. 4) as well. In the first kind of reasons contact were made because of workplace adaptations or how they could help the employee in the integration process, e.g. he/she asked how and what can help the best. One professional mentioned that he/she was only contacted in positive cases were the employer wanted to help the employee. "*Das waren die positiven Faelle – die anderen melden sich naemlich nicht beim Arzt – wo gefragt wurde, wie der Arbeitgeber helfen kann*." (MHP7, p. 4)

But interviewees mentioned cases where employers tried to get 'information' about the absent employee or where the employer tried to exert influence on the professional, too. As a result of the clients employer contact, professionals made a point of being bound to professionals' discretion and that they only could talk to the employer in accordance with the patient. In the 'positive' cases, professionals tried to be an intermediate as expert between client and employer (e.g. possible job rotations in a case of mobbing, worksite adaptations, attendance in the retention progress, acquisition of financial grants, etc.).

[31] Translation: "If there are difficulties in the family (e.g. stress also within the family and not only work related), then I talk with the patient about his family und with his consent also with family members."
[32] Translation: "For 'good' as well as for 'bad' reasons."

2.2 Illustrations from Cases

In this chapter we report about a specific section in the interview guides where we asked the professionals about so called "case studies". The interviewees had to recollect two cases one where a patient with a stress related condition successfully returned to and another one where a patient with a stress related condition did not return to work.[33] Then by referring to each case the interviewer prompted with two questions within each case: *What were the most important factors in aiding the individual to return to work* and *what factors could have prevented the individual going absent?* The aim of this design was to get insight in specific cases and get experts opinions and information about stress related absenteeism.

First of all we want to give some descriptions of cases in detail by professional groups to illustrate stress cases where the return to work process was successful and where the return was not successful. Here, we also describe the aiding or hindering factors mentioned by the professionals.

For instance one GP reported two persons with stress related symptoms. Concerning the successful return to work case, the GP mentioned the provided psychotherapy and the behavioural group therapy as the most aiding factors for return to work and that better knowledge of the contact with other people would have helped not to get ill. Communication training would have also helped to prevent becoming sick. Concerning one non-return case, the GP mentioned the case that the physical complaints and the individual hopelessness – due to the fact that his/her job was not granted – were dominant. In this case job rotation and half-time employment would have been necessary to prevent stress related sickness.

One HSR told about one returnee. The situation in this case was that his/her colleagues had appreciation of the situation of the person. The returnee had a lot of co-worker support which helped in the return to work process. Contrary to that case the mentioned HSR also reported from a case where the return process failed due to mobbing. In the first case it would have helped to solve the manpower shortage, and to reorganize the work duties between the employees would have helped for the not successful return to work case.

Moreover, one GM reported two stress cases where the redefinition of the function in the company was made in the successful return to work case. The time for reintegration was given and also a coaching with the supervisor was available. In the other case there was

[33] Nearly all of the professionals could recollect cases with stress related conditions. Interviewees who could not recollect stress cases where ask to concentrate on non-stress related cases.

dissatisfaction with the position and the mentioned person had low self-esteem to cope with the work duties. But the person was also in a conflict situation with the supervisor and all these factors were responsible for the failed return to work process. In both cases the GM concluded that a clear definition of the borderlines between task which are in the responsibility of the person and which aren't would had helped to prevent the sick leaf of the two stress cases. Also better leadership and more feed-back by the supervisor would have helped.

The factors in one successful return to work case brought in by one HRM were that in this case it was necessary to take away the time pressure and to strengthen the team work in the division. This had the positive effect that the mentioned person regained the pleasures of his/her work. The unsuccessful return to work case was described by the HRM in the following way: the consideration that he/she couldn't change the situation in the company was the main issue why the return to work failed. The person also had problems to cope with the development of the company. To avoid these sickness absence cases due to stress at the work place the HRM said that it was not easy to take away the pressure from work-life but maybe individual training (i.e. relaxation exercises, leadership training) of employees would have helped to cope with these situations.

Two interesting cases were also mentioned by one MHP. In this specific case, the professional said that the factors for a successful return to work were the raised awareness and the own realisation of the problems that caused the ill health. This person learned to identify the coherences of the background variables which where responsible for the stress. This person also took part actively in solving the problems and to regain complete health. The non-return case was described as following: it was the combination of the patient's attitude and the own frustration. In this case the work situation was very stressful for the person and he/she saw no possibilities to change anything.

By referring to all cases, professionals mentioned a mass of successful factors for return to work of employees with stress related conditions. Most often stated were work place and work site adaptations or occupational interventions. The contents had a wide range and we had to summarize the statements. Often mentioned aiding factors, especially by GMs and HRMs were work interventions and adaptations (e.g. reduction of working hours, change of work duties, regeneration, reduced pressure, team working, flexitime, etc.), supervisor's support (e.g. reemploy guarantee, dialog, etc.), communication (e.g. feedback, climate; co-workers and supervisor, etc.), information (e.g. health promotion campaigns, schoolings, etc.),

coaching and supervision. Another important role for return to work were personal factors which means the understanding of the patient, his/her personality (e.g. personal characteristics, coping strategies, self-esteem, awareness and knowledge, level of self-management, structure of life, motivation, etc.). The most important aspect, from the perspective of GPs, HSRs, MHPs and RTWs is the knowledge of clients' personality because this always helps to apply intervention strategies[34] and helps people to return to work consequently. Also social support from friends, family and colleagues was seen as very important factors to return to work.

About avoiding factors for individuals return to work one HRM significantly said: "*Wie so oft war es ein Zusammenspiel zwischen Arbeit und persoenliche Faktoren, in der Familie aber auch im Job*."[35] (HRM5, p. 4) This reflects the spectrum of statements given by the professionals. Hindering factors were mainly physical and mental problems (e.g. low/no hope and will, self-confidence and self esteem of the absentee; high resignation and frustration; depression, missing will of clients to understand the disease, addiction, no personal acceptance of the own situation, ineffective and insufficient treatment and intervention, loneliness, anxiety, strong empathy for other people, herniated disc, no time management, back pain, etc.), company or job factors (e.g. company structure, no understanding of supervisor, mobbing, lack of communication and information, pressure like "*Wenn du deinen Job nicht erfuellen kannst, brauchen wir dich ueberhaupt nicht mehr!*"[36] (GM2, p. 3), dismissal because of LTA, personal realisation that own job is the wrong and that the overload of the job, the conviction that one cannot change the inflexible organization and working conditions, no available employer for employment, etc.), satisfaction, support and conflict (e.g. conflicts with supervisor and co-workers, family and friend conflicts, low job gratification, no social support, low satisfaction with job position, etc.). Furthermore, some other factors like the financial situation, leisure time activities and return to work barriers because of the age of some LTA and therefore no retraining is granted were often stated by the professionals. One RTW specialist pointed out the fact that reintegration often isn't successful because the absentee was alone, he/she couldn't cope with the problems and the person therefore needed support from others. If there was no will to get the support or when the client "(…) *auf Wunder wartet*"[37] (HSR1, p. 2), help and reintegration often fails.

[34] Interventions mentioned e.g. psychotherapy, behavioural group therapy, wellness, sport, massages, discussions, reflection, information, medication, etc.
[35] Translation: About preventing factors for return to work "(...) it was so often an interplay between work and personal factors; in the family as well as in the job."
[36] Translation: „If you cannot fulfil your job, we don't need you anymore."
[37] Translation: "(…) waiting for wonders"

Factors which could prevent people going absent[38] in successful and in not successful return to work cases were also very often based on working conditions like e.g. flexitime, possibility of more work breaks, sport during breaks, possibility for a nap, other payment scheme, autonomy at work, better work climate, job rotation because of supervisor conflict, more employees to reduce time and work pressure, better leadership, clear definition of job profile and duties, qualification of supervisors, feedback, relaxation exercises, an adequate job, prevention and occupational health promotion programs, etc. Other statements were in another direction and namely things like awareness rising through lectures and schoolings, a better communication with others (e.g. communication training), supervision, coaching for supervisors, and appraisal interviews. Despite these, healthy food, other life-style, sport, wellness, relationship, economic and financial pressure, more adequate laws concerning working conditions, better considerateness on individuals 'pace', job change, family factors, etc. were also stated by the professionals and was seen as factors which could prevent employees going absent from work.

[38] Note: The statements came from all types of professionals and no significant differences between them could be found in the analysis.

Section 3: Description by Themes

In the last chapter we tried to give a detailed overview of the issues and trends which arose. We are now presenting some descriptions of differences and similarities between categories of professionals. This chapter is divided into several sub-paragraphs and is dealing with the level of awareness, descriptions of beliefs, issues about stress and absence, effective intervention strategies, and stress and absence from a work/family-perspective.

3.1 The Level of Awareness about Stress and Absence

The huge majority of the interviewed professionals observed an increase of stress over the past five years. Stress in the workplace has increased in the opinion of 29 professionals, only few noted no change, and no single professional indicated a decrease of stress in the workplace when comparing the last five years. No minor difference between categories of professionals could be found. All GPs and all MHPs stated that stress (as a complaint) was "frequently" (9 of 15) or "sometimes" (6 of 15) referred to when the client is describing their condition.

The main reasons for the perceived development of stress were differently seen by professional groups. Professionals working in or for companies mentioned the economic and labour impact on stress more often. GPs and MHPs also stated the changed labour situation but personal relationships, living conditions, and cultural changes in general as well. RTWs also raised the economic pressure on employees as main reasons for the general increase of stress. But in general, the causal chain of (global) economic pressure on companies and therefore the pressure on the employees as a source of stress is generally seen as an important reason of stress.

Concerning the experience of diagnosing stress, the stress recognition of professionals varies significantly between types of experts. Based on the professionals' statements, the latter of percentages of clients or patients whose primary diagnosis is stress related reaches from 1% to 90%! The interviewed GPs reported 25% to 70% (arithmetic mean 43%); the MHPs estimated 20% to 90% (mean 42%); and the RTW specialists 1% to 60% (mean 32%). These results show very inhomogeneous numbers both within and between groups of professional categories (grand mean 41%, minimum 1% and maximum estimation of 90%).

All HSRs, GMs and HRMs have experience in diagnosing stress and all of the professionals of these categories – *without exception* – have know-how with diagnosing stress within their employees. However, the way and the signals used to recognise stress differed notably between the professional groups. Also all interviewees were sure that 'their' employees knew how they could get information about the organizational health services and programmes (including stress programs). The odd thing was that the minority of HSRs, GMs and HRMs reported of the existence of an organizational definition of stress. Only 3 of 19 professionals said that their organization was using an explicit stress definition.

3.2 General Description of the Beliefs held about Stress

From questions about descriptions, beliefs and definitions of stress we got a lot of useful information from the various types of professionals. In addition, the stated information indicated that the definitions of stress used were quite differently. In general, we can conclude from the analysis that the most frequently used description of stress is time pressure, when somebody has too little time for the tasks to do. The examples of these stress situations came from more or less every interviewee across all types of professional category. They also described this situation with overload and excessive demands. Stress was also described as unclear work inputs and guidelines from supervisors and the problem of not knowing how to solve a (work) 'problem'. Not so often mentioned was the viewpoint of other professionals who defined stress as contradictoriness between family and work, which was a definition of stress arising from an imbalance between family and work. This input mainly came from HSRs and MHPs defined it in a similar way but more general: stress is strain over a longer time period without adequate coping strategy such as relaxation. Stress is an imbalance between tension and relaxation and therefore needs an adaptation.

Most of the professionals had, not surprisingly, experiences with the recognition of stress. The approach in stress recognition of HSR representatives, GMs and HRMs most often went via communication with the 'patient' where they found the 'typical' complaints and symptoms and also because of the emotional and physical reactions. Whereas GPs started with the obligatory medical talk and screening and then they further investigate for stress also when the patients' presents other conditions as stress related symptoms. Referrals to medical specialists are then often common practice. Noteworthy, GPs are not diagnosing stress, anxiety, fatigue and burn-out most frequently. Instead of this, backache and depression were

most often stated by GPs and depression symptoms were most often diagnosed within the MHPs. Furthermore the estimated percentage of patents with stress related conditions in their client base has a wide range and indicates extremely differences of stress recognition not only within the GPs, also within MHPs and RTW specialists as well. When asking for the knowledge requirements, professionals tended to express that they had sufficient knowledge and awareness about stress! The minority articulated insufficiency.

3.3 The Issues raised in Relation to Stress and Absence

Employees who were suffering from stress or stress related complaints could be helped in different ways depending on their current situation. On the one hand, factors could be applied to prevent people going to sick leave or absent. Also when employees are absent from work because of stress related conditions some things can be done to assist them to return to work successfully. We asked the professionals for their experiences which their gained from their work.

Professionals gave us useful hints concerning factors which could prevent people going absent when stress was the problem.[39] First of all changed working conditions could prevent absenteeism as well as "life-style" factors (Note: A list of possible changes was already provided above). The conclusions from successful RTW factors were more or less the same. Very important, from the professionals' perspective, were work place and work site adaptations, occupational interventions reaching from the kind of work itself (e.g. pace) to the work environment (e.g. co-workers or supervisor). The personality of each individual case (e.g. coping ability) also seemed very essential. Supplements were also gained from professionals' answers concerning the hindering factors for individuals' return to work. The most important statements were that the RTW process was sometimes very difficult because of the multiple causes and interdependences of (stress related) complaints. It was a complex interaction between job, family, and person.

Because of this, it seemed to be consequential that it was very important to detect the concrete problem or situation at first, the individual or a significant other (e.g. family member or colleague), and then in a second step – because no single case is like the other – to look at personal and other characteristics to target the problem. Accordingly, interventions could be applied. This also means that this needs very watchful and active persons, significant others

[39] Concerning professionals' answers, no relevant differences between types of professionals can be reported and therefore no differentiation of the statements will be done here.

(e.g. family members, friends, co-workers, colleagues, professionals, etc.) as well as the individuals themselves.

3.4 The main Interventions described

The interviewees (GPs, MHPs, RTWs) recommended several interventions when a client had a stress related condition. Most frequently they recommend Mental Health Services (all three types of professionals), Non-health Interventions (mainly MHPs and RTWs) and Allied Health Interventions (mainly GPs and MHPs). Professionals also rated Mental Health Services, Non-health Interventions (both mentioned from all professional categories very often), Alternative Interventions (GPs, MHPs, RTWs), and Allied Health Interventions (GPs and MHPs) as the most effective intervention possibilities.

Additionally asked for frequently used effective intervention or treatment, professionals often mentioned that interventions/treatments were only effective in combination with each other. Only a combination of different approaches could yield a success and these needs preliminary the professional to take the client seriously and an individual co-ordination of things to be done. Absolutely not helpful were things which pressurized the patient and interventions or treatments which only aimed to diminish the effects of the stress related condition. To find the most effective intervention, it is inevitable not only to consider the symptoms but also the underlying factors.

On the other hand, work site professionals were asked for changes made for people with stress symptoms. All professionals asked did something and most frequently mentioned were the provision of technical aids/adaptations (HSRs, GMs, and HRMs all said they applied them very often), a change of the employment condition (GMs and HRMs), and changes of the work environment (HSRs and GMs).[40] To prevent employees from going out absent, the organization the interviewees were working for most often offered information and communication programs for the employees such as information campaigns about stress. Health or health promotion programs (e.g. periodic health screening) and work changes (e.g. structure, condition, environment, etc.) were then at the second place of most often applied support of the organization. HRMs stated significantly more often occupational interventions than GMs and HSRs did. Only minor differences could be observed within the other mentioned categories of organizational offers.

[40] The enumeration mirrors the statements of more than 14 of 19 professionals.

It seems noteworthy, that professionals weren't able to name any organizational action aimed at persons who were out on long-term sickness absence due to stress and other related conditions.

3.5 Stress and RTW – Effective Interventions and Activities

As interventions and activities for people with stress related conditions are concerned, HSRs, GMs and HRMs mainly suggested three distinctive actions. First professionals thought that more information, better knowledge, better and more schoolings and programs could help employees with stress related conditions. In this regard, awareness about stress, its sources and how stress works and arises, was also very often proposed by different professionals. Secondly, organizational changes and work adaptations including development of a better communication climate were stated often. Individual interventions including coaching and the availability of a confident person within the organization to whom could be talked to with stress related 'problems'.

The differences found between professionals were not very large. HSRs recommended more information sources (e.g. schooling, knowledge, awareness) than intervention strategies and activities in relation to stress and return to work. On the contrary, GMs preferred more individual approaches (e.g. coaching) and both GMs and HRMs were in favour of organizational adaptations more often.

3.6 Opinions about the Causes of Stress

Generally, we have to mention that there was a general perception that clients often did not speak about stress because stress was not perceived as the main 'problem' though difficulty meant stress for the patient. An interview partner expressed it this way: "*Die KlientInnen reden nicht ueber Stress, weil fuer sie Stress nicht das Problem ist.* (…) *jede Problemstellung bedeutet eigentlich Stress*."[41] (RTW6, p. 2)

When clients talked about stress, the job was most frequently mentioned as the main source. Approximately 60% of all answers (given by professionals) could be counted for this category. Secondly, personal, family and relationship causes of stress were also very

[41] Translation: "Clients don't talk about stress because stress isn't the actual problem. (…) each challenging situation means stress."

frequently mentioned by clients when talking with professionals (approximately one fourth of all responses). Health and financial problems were mentioned less often in this context.

Another ranking was reported by one MHP. The interviewee reported that family problems and problems with a relationship were in most cases factors which were responsible for stress. Furthermore, financial problems and job dismissal as a cause of stress could be observed very often. Health problems, which were connected with stress, were in the third position in the stated factors in the causal chain for stress.

To highlight the various perceptions, the differences between the types of professionals were that factor job for stress is most predominant within the HSRs, GMs, and HRMs. Whereas the other professionals (GPs, MHPs, RTWs) also stated a lot of other stress factors named by their clients. Differences also emerged between categories of professionals when providing a prompted list of stress causes. There, HSRs, GMs and HRMs stated job as the causal factor of stress most often and RTWs tended to state finances, health and loneliness as stress factors frequently. GPs and MHPs had completely different patterns in their answers. GPs refer to health, relatives, relationship with partner, job, death/mourning, and loneliness very often; MHPs mentioned factors like health, relationship/partner, job, sleep, death/mourning, and loneliness as often defined causes of stress by their patients.

Section 4: Discussion

This chapter addresses several issues from the professional study and this reflects researchers' perspectives and impressions which were gained during the interviewing process and the interpretations as laid out in previous chapters.

4.1 Current Approaches adopted to Stress and Absence within Austria

Stress has been defined in a multitude of ways but following a generic definition, stress is the consequence of a long-term process in which people have been exposed to demands that exceed their capacity to cope. In this respect we can say that stress is a continuing development not only a short-time cause. Another part of the definition describes this long-term process more in detail. Stress is the result of high demands on the individual. If so, the individuals have to deal with the situation which means that the person has to handle and to solve it in the last consequence. The behaviour of the individual in this respect is the coping strategy.

Per definition, stress is a result of an enduring process in which people receive demands which can result in an imbalance between the individual coping capacities and these demands. The definition is a little bit uncertain how 'demands' are defined. On the other hand the definition states something about the individual's 'capacity to cope'. This stress definition tells us nothing about how/in what way people cope with this long-term exposition to demands but the capacity seems to vary from person to person because it can be exceeded.

With this overall definition of stress in mind we can confront it with definitions and models of interviewees of the professional study. By looking at all the answers and statements it is obvious that not all professionals are talking about the same.

Most of the experts defined stress, speaking of negative distress, as the consequence of ill health and the (unhealthy) demands individuals are exposed to. All answers have in common that stress is an output of something; as a consequence, stress is then the simple output of the individual's exposition to high demands. Interviewees described the high demands mainly as overload, pressure, restriction, conflicts, environment, family/work-imbalance, pain, etc. The majority of interview partners haven't noted that stress exposition 'needs' a longer period of time. Maybe this was implicit but only few mentioned it explicitly. The same conclusion can be drawn from the coping part of the stress definition. Not many talked about the individual's need for compensation of demands. Nevertheless, some did and expressed the compensation

like this: to have too little resources for the demands, not to be in the balance, being without adequate compensation, or without enough relaxation phases.

From the answers and during the analysis procedure it became obvious that different professionals have different definitions of stress. As already told the most 'popular' definition of stress is through taxation enumeration of several demands people could be exposed to. In our sample of experts, the whole definition is not always given but it's worth knowing that exceptions existed, i.e. especially the MHPs. Moreover, it's a misfortune that we couldn't get more information about the companies' definitions of stress the interviewed experts are working for. This would have been another source of stress definitions but only three of 19 representatives from organizations told us that an occupational stress definition exists.

To sum these facts up, experts have different and partial definitions of stress in mind. However, the systematic detection means that all actors need appropriate awareness and sufficient knowledge of stress and stress related conditions. All professional groups are needed because the stress issue is connected between several fields of action – reaching from the workplace to the return to work process.

4.2 Understanding of Stress and Work - Respondents' Satisfaction

Concerning the stress diagnosis, some GPs only mentioned that the patients often negated stress and they sometimes didn't want to accept stress as a diagnosis. This produces difficulties with the understanding of the patients. On the other hand, the impression of GPs was that nowadays it is trendy to have stress as long the individual is 'controlling' the stressful situations but not suffering from. But all in all the interviewees, i.e. GPs stated no problems when diagnosing stress in a patient and no reservations in using the diagnosis of stress related condition at all.

Coherent to this result, most of the professionals mentioned that they had sufficient knowledge and awareness of stress to deal with most situations that arises on behalf of their clients. Eighty percent or 33 of 40 interviewed professionals answered with "yes", indicating sufficient knowledge and awareness of stress. Only 2 HSRs, 1 GM, 3 HRMs, and 1 RTW specialists answered to the question with "*no, I don't have sufficient knowledge and/or awareness of stress*".

Looking at these results, one would expect that the estimation of the percentage of the professionals' clients with a primary diagnosis of stress related complaint would be very

homogenous across and within each type of professional. If we go on and assume that each professional also has nearly the same relative amount of stress patients based on their client base, then we would expect that all professionals estimate more or less the same percentage of clients with stress related conditions. This was definitely not the case. GPs' estimations of the percentage of their clients with a stress related diagnosis reach from 25 to 70%, MHPs estimated between 20 and 90% and RTW specialists estimated a percentage between 1 and 60%. These were huge differences within professional category from 45% to 60% as well as across all categories of professionals. These estimations have an absolute difference (between highest and lowest value) of nearly 90%![42]

All GPs and MHPs were asked whether they wished a higher involvement in the return to work process of patients with stress related conditions. Whereas all of the interviewed MHPs answered with "yes" to the question, the statements of the GPs were split. Half of the GPs wished (more) involvement and the other half said "*no, I should not get involved in this process*". Arguments against and caveats are further time and cost problems, and the additional demands which arise when being involved in this process.

[42] By excluding outliers in the analysis and the difference between lowest (29%) and highest value (52%), based on the 95% confidence interval is therefore 23% with a median of 32 and a standard deviation of 22.

Section 5: Conclusions and Recommendations

In the last chapter we wanted to draw some conclusions and define recommendations mainly from the underlying professional study and its results described above. Here we mention some points which are, in our view, important for the issues of stress and absence.

5.1 The Salience of Stress and Absence as a Problem

From the Professional Study we can conclude that both the incident of stress in the workplace and the frequency of stress related complaints have increased over the last years. The reasons are mainly the changed work and work related conditions resulting from higher demands from global economy and the increased pressure on the companies. Despite this also problems in personal relationships and other living conditions were addressed by the professionals as well as changed life-style and changed society as well.

Professionals in Austria responded that stress (as a complaint) was frequently referred to when a client was describing his/her condition. Professionals estimated that about 40% of their clients have a primary diagnosis of stress or a stress related condition. These are alarming numbers for all individuals, their families, professionals, the community and the society as well.

5.2 Satisfaction of Understanding and Knowledge of Stress and Absence

Professionals use very different signals to recognise stress. That is no surprise as one aim of the study was to interview professional from different fields and areas. As a consequence GPs, MHPs, HSRs as well as GMs, HRMs and RTW specialists were included. On the other hand, experts noted to have a lot of experience with stress and most of the professionals responded to have no reservations with diagnosing stress. They assume that they have sufficient knowledge and awareness of this issue and are able to deal with most situations that arise on behalf of the clients. Only some interviewees articulated the need for more information about particular areas of stress.

The surprising aspect was the fact that professionals gave very inhomogeneous estimations of the percentage of clients with the primary diagnosis of stress or a related condition. They differ greatly from expert to expert and from profession to profession.

That could be an evidence for very different knowledge bases or insufficient definitions of stress and how it works.

5.3 Confidence in current Approaches to Return to Work and Stress

The minority of professionals ask their clients/patients whether he/she is absent from work or not. This is an odd result because the recovery from illness and the return to work object should be an important aim for professionals. Also some professionals expressed that they should be more involved in the process of returning patients with stress related conditions back to work. Some answers are indicating that the main obstacle for this deeper involvement are arguments like the lack of time or money and that they are not educated adequately in this way. When this is the case, referrals should be made. However there was no sign in the answers that professionals in Austria do not refer to other professionals. Family member involvement seems also common practice.

Work related professionals also seek for occupational arrangements and adaptations to assist a returning employee. Company representatives mainly distinguished between short-time and long-time absence and which adaptations and arrangements could help. An ad-hoc hypothesis could be that company assistance highly depends on the company (e.g. size, culture, etc.) and the arrangements were sometimes not sufficient. Evidence for this conclusion mainly came from two results. First of all, not many GPs, MHPs, and RTWs have had contact with the patient's company so they have had a lack of information to consider adequate interventions. Secondly, more or less all professionals stated an increase of stress in the last years and that the occupational "environment" is primarily responsible for this recent development. This is a strong indicator that the occupational situation is not always a healthy setting.

5.4 The Adequacy of System Responses

The system recognises an increase of stress and related conditions but individuals and professionals dealing with different and sometimes with insufficient awareness, knowledge and therefore with inadequate approaches and definitions of stress. Many different people on different levels are involved in the system. This affects sometimes an inefficient output and many people suffer from stress and related ill health. The individuals are struggling

with the situation; absenteeism is often the effect and produces high system costs. The improvement of the system adequacy must be the aim.

5.5 Recommendations for Future Action

Stress has a great impact not only on the individual but also on family members, companies and communities, as well as on the societal level as a whole. The impact is not only an impact on one's health, stress and stress related conditions are also combined with the job condition, has social impact and financial and legal consequences at all levels from the individual to the society.

Mainly because of this recent trend, stress is more salient and present with the consequence of ill health and absenteeism which produces enormous personal and societal costs. Sickness absence can therefore be conceptualised as an individual decision making process and this decision depends on the health, job, social, but also depends on financial and legal aspects. A good example is the so called epidemiological sickness absence rate showing that the overall and business specific rate correlates negatively with the macro economic situation.

All levels are affected and therefore it is easy to argue that all societal levels, *micro* (e.g. individuals, families), *meso* (e.g. companies, communities) as well as *macro* (society) play their role in the system. The easiest example is that the employees' health and work absenteeism is producing financial losses at the company and the society level as well.
A *top-down-bottom-up model* could be ideally the best to promote health issues in general. Also intermediate actors, such as the media, could be initially conceptualized in this model and for better output policy adaptations in this respect should be discussed. A preliminary list of actions is an initial and continuing professional development, a knowledge management and an information sharing, awareness raising, policy development and regulation, capacity building, recommendations for more effective system responses, and next steps and actions towards a more effective response to stress and absence by professionals.

The results from this professional study provide some insights into professionals' work and experiences. It is only one part in a study series in the Stress Impact Project. In addition to the first study, which surveyed long-term absentees, and the third, the family study, it is expected to obtain more insight in problems, experiences and needs concerning an issues, which is a

challenge for individuals and their significant others, the economy and the society as well: Stress and stress related complaints and their consequences.

Appendix 1: Profile of Professionals

This part of the appendix introduces the professionals who participated in the study. Below, for each professional group small vignettes are presented to have some useful information about the persons. The information provided is short and not concrete to grant anonymity of the participating professionals. Additionally, each professional group is coded with a acronym (GPs, … , RTWs). Within each type of professional each expert also got an ascending digit (1, 2, … , m).

General Practitioners (GPs)

Gender	Years of Experience	Location of Practice	Client Base
Female	4	Outside Vienna	Public
Female	10	Outside Vienna	Public
Male	6	Vienna	Public
Female	13	Outside Vienna	Public
Male	20	Outside Vienna	Public
Male	20	Outside Vienna	Public
Female	1	Outside Vienna	Public

Health & Safety Representatives (HSRs)

Gender	Years of Experience	Location of Practice	Client Base
Female	10	Vienna	Private
Female	5	Outside Vienna	Public
Female	10	Outside Vienna	Private
Female	3	Outside Vienna	Private
Female	7	Vienna	Private
Female	20	Outside Vienna	Private

General Managers (GMs)

Gender	Location	Sector	Number of Staff
Male	Vienna	Private	20
Male	Vienna	Private	6000
Female	Vienna	Public	1000
Male	Vienna	Private	20 + 80-100 freelancer
Male	Outside Vienna	Private	2000
Female	Vienna	Public	3000
Male	Vienna	Private	2000

Human Ressource Managers (HRMs)

Gender	Years of Experience	Location	Sector
Male	5	Vienna	Private
Male	1	Vienna	Private
Female	10	Vienna	Private
Female	7	Outside Vienna	Private
Female	8	Vienna	Private
Male	5	Vienna	Not for Profit

Mental Health Professional (MHPs)

Gender	Years of Experience	Location of Practice	Type of Clients
Female	30	Vienna	Psychiatry, Neurology
Male	10	Outside Vienna	Mental Disorders
Female	8	Outside Vienna	Depression, Post Traumatic Stress
Female	15	Vienna	Mental Disorders
Female	17	Vienna	Depression, Anxiety and Panic, Psychoses
Female	5	Outside Vienna	Stess and other work related Problems
Male	20	Vienna	Neurology, Psychiatry
Female	20	Vienna	Psychiatry, Stress

Return to Work Specialists (RTWs)

Gender	Years of Experience	Location of Practice	Client Base
Female	10	Vienna	Persons with Work and Health related Problems
Female	3	Vienna	Persons with Work and Health related Problems
Male	10	Vienna	(long-term) Unemployed
Female	4	Vienna	(long-term) Unemployed
Female	4	Vienna	People with all kinds of Mental Disorders
Female	15	Vienna	(young) Unemployed

Appendix 2: Roles and Responsibilities of each Professional

General Practitioner

A General Practitioner is a practicing medical graduate. He/she is the first contact point for a patient when medical problems are given. General Practitioners are players in the primary health care of all patients with physical or mental disorders in cases of emergency, acute and long-term supply. They also cover areas of prevention and rehabilitation. They are also specialists to be the first medical contact in the case of health problems.

Health & Safety Representative

Health and Safety Representatives are Occupational Physicians or Safety Representatives within an organisation. The Occupational Physician deals with work related problems and the interactions between work and health issues, especially with work related health risks, occupational diseases, safety at work and protection of accidents. His/her duties are also to integrate disabled employees in the work process. The Safety Representative represents the employees. His/her responsibilities are to inform and assist employees about safety and health protection in the workplace.

General Manager

A General Manager is an executive who is in most times in the middle or high levels of a company. In the company he/she has different responsibilities: representative, supervisor, net worker, speaker and the manager is responsible for innovation, distributes resources, solves problems and administrates.

Human Resource Manager

The Human Resource Manager links employer and employee. He/she is responsible for the administration and administrates the skills and experiences of all employees in the company. On this basis the Human Resource Manager analysis the potential for development but he/she is also very often responsible for the calculation of salaries.

Mental Health Professional

This group includes several Professionals: Psychiatrists are diagnosing and treating mental diseases or dysfunctions. He/she is looking at the relationship between physical and mental problems and their reciprocal interchange. Psychologists have profound knowledge about human thinking and behaviour and they know how to change human behaviour. Clinical

psychologists work and health psychologists cover special areas in the field of psychology. Whereas Psychotherapists treat mental, emotional and psychosomatic caused diseases, problems and behaviour dysfunctions.

Return to Work Specialists

The Role of a Return to Work Specialist is to facilitate the return to work of people who are sick, injured or long-term absent from work due to a medical reason or due to unemployment.