

Occupational Health Psychologist



Incorporating the Newsletter of the Academy

A publication of the European Academy of Occupational Health Psychology

Europe's leading body for individuals and institutions with an active involvement in research, professional practice and education in occupational health psychology

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Editorial

Welcome to the third and final 2005 issue of the *Occupational Health Psychologist*. We are once again delighted to present a number of articles that provide information on the activities of our fellow occupational health psychologists.

As this has been the first year since 1998 without a full EA-OHP conference, we are particularly pleased that the *OHPist* has provided a forum for you to communicate your work. We send a note of thanks to all of you who contributed to this publication over the past year (previous issues can be downloaded at <http://www.ea-ohp.org/>).

In this issue, we have included four informative articles from the research team at TNO (The Netherlands). Our thanks go to John Klein Hesselink and his colleagues, who have stayed in touch with the *OHPist* editorial team since last year's EA-OHP conference in Oporto. We feel very privileged to be able to highlight the important work being conducted at TNO, and we are confident that these excellent articles will help to further raise the profile of this publication.

We also bring you a fascinating article by Professor Satoru Shima and his colleague Emi Satoh on the emergence of occupational health psychology in Japan. These authors describe the demands being faced by workers in Japan, which reflect a number of economical, societal, and cultural changes. It is clear that the growing number of OHP professionals in Japan have a crucial role to play in reducing the impact of work-related ill-health.

In addition to these articles from Holland and Japan, Mary Tisserand (Assistant Editor of *Work and Stress*) provides details of a recently published special issue of *Work and Stress*, which focuses on burnout. Mary has kindly offered to provide us with regular updates on the Journal in forthcoming issues of the *OHPist*.

We have already received some submissions for our 2006 issues, including a series of papers relating to research and practice in the UK National Health Service, a report from Sweden on the consequences of exposure to harassment at work, and the experiences of German student who completed an OHP Masters degree in the UK, before returning to Germany to become an OHP practitioner.

As always, we are keen to encourage more of you, our readers, to send us information on your OHP work. We welcome many different types of articles, as is outlined on the final page of this issue.

Preparations for the 7th conference of the EA-OHP in Dublin, Ireland are now well underway, thanks particularly to the efforts of Jonathan Houdmont (the Academy's Executive Officer) and Patricia Murray (Irish Health & Safety Authority). The venue (Dublin Castle) will provide a spectacular setting for the conference, and there are a number of exciting social events being planned to keep delegates entertained outside of the scientific programme (further information on the Dublin conference can be found on page 3 of this issue).

All that remains is for me to wish you a peaceful festive holiday, and a prosperous New Year.

Best wishes

Paul Flaxman

On behalf of the Editorial team

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Disclaimer

The views expressed herein are those of the authors and do not necessarily represent those of any other person or organisation. The *Occupational Health Psychologist* does not in any way endorse the views expressed.



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Work & Stress

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Conference Proceedings

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Comprises the proceedings of the EA-OHP annual conference. Previous editions may be ordered at a cost of £25 per copy or £125 for the entire back catalogue. The catalogue consists of Lund (1999), Nottingham (2000), Barcelona (2001), Vienna (2002), Berlin (2003) and Oporto (2004).
Copies may be ordered from Jonathan Houdmont at jonathan.houdmont@nottingham.ac.uk

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Thomas Rasmussen (University of Aarhus) presents his work to EA-OHP conference delegates. Information on the research being conducted by Thomas and his colleagues can be found in the previous issue of the *OHPist* (available at www.ea-ohp.org)



7TH CONFERENCE OF THE EUROPEAN ACADEMY OF OCCUPATIONAL HEALTH PSYCHOLOGY

Dublin, Ireland, 8-10 November 2006



THEME

Dublin 2006 promises to offer a truly international conference that provides a global perspective on research, practice and education in occupational health psychology. Papers, posters, symposia and workshops from all areas of occupational health psychology are welcomed. Keynote presenters include Maureen Dollard (University of South Australia) and Norbert Semmer (University of Bern, Switzerland).

VENUE

The Irish Health & Safety Authority is hosting the three-day event at the spectacular Dublin Castle in the heart of the city. The modern, purpose-built, International Conference Centre was constructed for Ireland's Presidency of the European Union in 1990. A full and exciting social programme has been provided to ensure a memorable social, as well as intellectual, meeting.

CALL FOR PAPERS & DELEGATE REGISTRATION

Abstract submission closing date: **31st March 2006**.
Delegate registration: **1st January – 1st October 2006**.

CONFERENCE CONTACTS

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THE EA-OHP

The European Academy of Occupational Health Psychology exists as the sole European body for the promotion of research, education and professional practice in occupational health psychology. The discipline concerns itself with application of the principles and practices of applied psychology to occupational health issues, with the objective of enhancing our understanding of psychological, social and organisational aspects of the dynamic relationship between work and health.



News from the editorial team

Tom Cox and Mary Tisserand
Work & Stress, Nottingham, UK

Associate Editors

The journal has had a busy year, and we were pleased to learn that its impact factor had risen to 0.935. We are also delighted to welcome five new Associate Editors to join Frank Bond. They are Philip Dewe (London), Bonita Long (Vancouver), Kathryn Mearns (Aberdeen), Arie Shirom (Tel Aviv) and Toon Taris (Nijmegen). Their combined experience is considerable, and we are certain that the journal will benefit greatly from their involvement.

Fast track processing

With regard to contributions, we identify some newly submitted papers as particularly interesting, topical or important. We give these papers priority treatment and quick publication, but without compromising on standards. If you believe that you have such a paper, do contact the journal.

Electronic submission

This was temporarily suspended for technical reasons. We appreciate that electronic submission is a facility that is useful to contributors, and the journal's website will shortly announce that it has been reinstated. We welcome the electronic submission of papers, which should be e-mailed to Mary Tisserand (see email address in box below).

Burnout edition

Most of the third edition of *Work & Stress* for 2005 (Volume 19 part 3) is devoted to the subject of burnout. Whereas a great deal of research is being conducted in the field, there is also still much to be learned and a need for consensus on its conceptualization. The conceptualization and measurement of burnout are dealt with in this edition, which includes several original papers, commentaries, and an Editorial.

The first two main papers present two new instruments for measuring burnout. The first one, on the Copenhagen Burnout Inventory (CBI), is by Tage Kristensen and his colleagues from Copenhagen. The CBI is already in use in several countries and is, the authors argue, in several respects an improvement over the Maslach Burnout inventory. The second instrument is the Oldenburg Burnout Inventory (OLBI). Jonathon Halbesleben from Missouri, US, and Eva Demerouti from Utrecht in The Netherlands, investigate the psychometric properties of the OLBI and conclude that it offers a useful alternative to the MBI.

In the third main paper, Marrie Bekker and colleagues from Tilburg in The Netherlands examine the relationships between several gender-related variables and emotional exhaustion and sickness absence. Like Kristensen, they exemplify the "unidimensional" approach to burnout, since they use only the emotional exhaustion subscale of the MBI.

In the final main paper Toon Taris and his colleagues from Nijmegen, Utrecht and Amstelveen, review and test process models for the development of burnout. They report some longitudinal evidence for a causal order, and suggest that future researchers look at the possibly beneficial role of depersonalisation.

Commentaries and editorial

Interestingly, the four main papers illustrate different approaches to burnout, and we invited three leading researchers in the field to use them as a basis for commentaries on the status of current research.

In the first commentary, Wilmar Schaufeli and Toon Taris respond to the criticisms of the MBI that are raised by Tage Kristensen. They have some common ground with Kristensen, but in other respects are "worlds apart". In the second commentary, "Reflections on the study of burnout", Arie Shirom from Tel Aviv discusses some of the similarities and differences between the various approaches to burnout represented in this edition.

Shirom also comments on the chronic nature of burnout, and the need for a consensus on its definition. He compares it with other affective states, and urges researchers to pay more attention to distinguishing it from depression. Finally, Sabine Sonnentag from Konstanz, Germany argues for closer attention to be paid to the possible benefits to the individual of the depersonalisation (or cynicism or disengagement) aspect of the construct, and for research that examines fluctuations in burnout over short periods of time.

The Editorial -- written by the journal's Editorial Team, Tom Cox and Mary Tisserand, together with Toon Taris -- brings together all these contributions, uses them to examine the current status of burnout research and attempts to identify the main problems that remain to be resolved. They discuss five main issues for future research. Is burnout a multidimensional construct? Does it depend on context (e.g. work conducted in the human services)? Does it differ from stress? Is it a continuous condition, or is there a threshold? Do we understand its causes and developmental processes?

We hope that this special edition of *Work & Stress* will stimulate research and debate. Comment on the issues raised in the edition will be welcomed, and can be sent to either the editorial team or this Newsletter. The full papers can be accessed online via the journal's page on the website of the

publisher, Taylor & Francis, at:
<http://www.tandf.co.uk/journals/tf/02678373.html>

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Shirom, A. (2005). Commentary: Reflections on the study of burnout. *Work & Stress*, 19, 263 - 270.

Sonnentag, S. (2005). Commentary: Burnout research: Adding an off-work and day-level perspective. *Work & Stress*, 19, 271 - 275.

Taris, T.W., Le Blanc, P.M., Schaufeli, W.B., & Schreurs, P.J.G. (2005). Are there causal relationships between the dimensions of the Maslach Burnout Inventory? A review and two longitudinal tests. *Work & Stress*, 19, 238 - 255.

Latest edition

The newly published final edition for this year (Volume 19 part 4) includes a paper by Sabine Geurts and her colleagues on the development and validation of another new instrument, the SWING (Survey Work-home Interaction – Nijmegen). The SWING measures multiple components across a wide variety of workers.

Also in this edition, Claudia Bernhard-Oettel and her colleagues from Sweden and Belgium compare full-time work with other types of employment, in a sample of Swedish healthcare workers, in order to investigate the possible effects of type of work on employee wellbeing.

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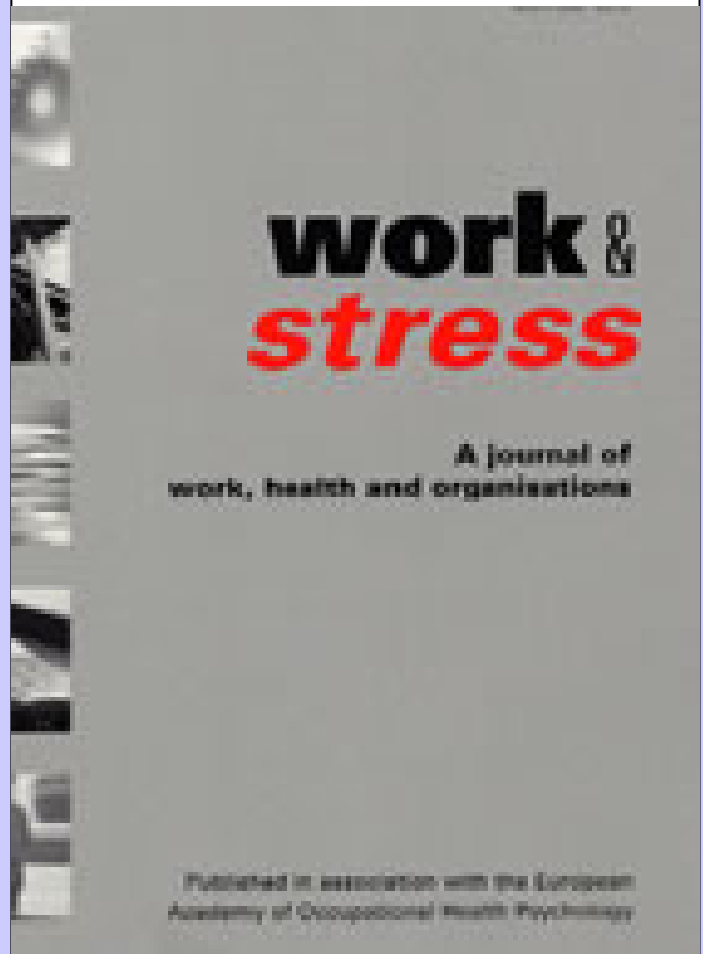
Work & Stress is an international journal on work, health and organizations. It is published in association with the Academy.

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Subscriptions

Academy members are entitled to obtain individual subscriptions to the journal at a much reduced rate (for 2006 this will be £56 as opposed to £122). Taylor & Francis is currently updating its website to enable Academy members to purchase individual subscriptions online and make payments in a variety of currencies. This facility should be operational early in 2006.



OHP in The Netherlands

TNO and the Application of Occupational Health Psychology in The Netherlands

By: John Klein Hesselink, TNO Quality of Life

We appreciate the opportunity the Occupational Health Psychologist offers us to present a picture of the work we do at TNO. We would like to present this picture by first explaining the role of our organisation in Dutch society. Next, we present three projects that are typical for improving occupational health in The Netherlands. Because we write our contribution for the Occupational Health Psychologist audience, we concentrate on the following subjects: psychosocial problems at work, work stress, and work organisation; however, this is only a selection of the many topics we deal with in our organisation.

What is TNO?

TNO was established in 1932 by the Dutch Government to stimulate the application of the results of natural science in trade and industry. Social science was integrated into our activities, particularly after World War II, when management and organisational topics became increasingly important. At this moment TNO is Europe's second largest research institute for technological and strategic research and consultancy. By bringing scientific knowledge into practice it is our aim to optimise the innovative abilities of industry and government. Our 5,500 employees cover a wide range of research topics and work daily on the development and application of knowledge. One of our favourite slogans is: 'We make knowledge work'.

Our organisation consists of five core areas: (1) Quality of Life, (2) Defence Security and Safety, (3) Science and Industry, (4) Environment and Geosciences, and (5) Information and Communication Technology. Under the heading TNO Quality of Life, we develop knowledge for national and international market clusters such as 'agriculture and food' and 'chemistry and pharma'. TNO Quality of Life is also an important partner for the government and public sectors in the area of healthcare and on work-related issues.

'Work and Employment' is a division of TNO Quality of Life, and plays a key role in Europe's occupational health and safety (OSH) research. In the Netherlands, we are leading on research and consultancy in the fields of: (1) ergonomics and physical workload, (2) new forms of work organization, (3) psychosocial factors at work, (4) national infrastructure on social security, (5) OSH, and (6) disability management. A development of the last five years is that we support companies to 'work smarter'. This helps us to promote investment in new ideas as an alternative to the customary organisational focus on cost savings in a declining economy.

What is the contribution of TNO to OSH?

Innovation is our key mission; we always try out new things and try to explicate what we have learned from them. We do this to provide industry and government with new ideas to improve work and the working situation. Innovation is also a leading subject in the projects that are presented on the following pages. After a description of each project, we concentrate on what we have learned from it.



Dr. John Klein Hesselink presents some of TNO's research at last year's EA-OHP conference.

The three projects we present are typical of the work we do as researchers and consultants at TNO. The first one is a research project for the Dutch Social Security Administration (UWV), which was designed to find out how we can prevent workers with psychosocial problems from entering the disability system. The second is a consultancy project in a health care organisation. This organisation asked us to help them upgrade from supply-oriented to demand-oriented working, and to reduce sickness absence. We embedded the answers to these questions in an employability context. The third project is a research and consultancy project for a large multinational organisation, which asked us to develop a self-supporting instrument for the detection and treatment of work stress.

OSH and social security in The Netherlands

Before describing our three projects, we need to explain some essential parts of the Dutch social security system. In The Netherlands, we do not distinguish between occupational and general health risks, as is often the case in other European member states. The general practitioner (GP) in our country is the entrance to the health care system, and the employer is responsible for the continuation of income, work, and employment. Both the employer and the employee are responsible for return to work as soon as possible in the case of sick leave. The occupational health physician assists the employer and the employee in this task. In former days, the income risk was insured by the social security system, in which all employers participated. Nowadays this system has been assessed as too costly and too susceptible for misuse. However, employers are still directly responsible for the continuation of salary payments for their sick and disabled employees, up to a maximum of two years after reporting absent. After two years, the disabled employee enters the social security system. This direct responsibility for continuation of work and payment in the case of sickness absence, and the high costs involved, is the motivation behind many of our projects on primary, secondary, and tertiary prevention, including the three cases studies described below.

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Predicting return to work in employees absent because of psychological problems¹

By: Irene Houtman and Birgitte Blatter, TNO Quality of Life

In the Netherlands, one third of the employees who enter into the disability system are diagnosed to be disabled because of psychological problems. This risk of receiving disability benefit because of these kinds of problems is high in the Netherlands: 1.5% per year for all employees. This risk has been somewhat declining since 2001 when it was at its highest (1.7%). The recent decline seems to be related to the economic recession that has hit the Netherlands relatively hard since 2001. Becoming long term disabled for work because of psychological problems, however, appears to be a more general problem than just in the Netherlands. Yet the share of the work force that receives disability benefit is relatively high in the Netherlands in comparison to other European countries, particularly where psychological disorders are concerned.

Societal debate on this issue concentrates on the long term (often permanent) financial costs of the drop out from the labour market. The real issue of course is why people with psychological health problems less often resume work in comparison to people who report sick because of other health problems. Research into this topic is, however, rather scarce. This was the reason to start a project to follow up employees for at least one year after they reported absent because of psychological problems.

Design and size of the cohort and response to follow-up

Dutch legislation states that employers should report employees who are expected to be long-term absent from work to the Social Security Administration. The reporting deadline is set by law at 13 weeks after reporting absent. When an employee is not reported to be absent to the Social Security Administration (UWV) before this deadline, and this employee ends up being absent for more than a year, the state payment of benefits will be shifted onto the employer.

In our study, somewhat less than 8,000 absent employees were approached via the Social Security Administration. These 8,000 were recruited from all employees who were reported absent by their employer before week 13 in the period of March until May 1999. All 8,000 employees were sent a screening questionnaire with a request to participate in a cohort study, and were additionally asked to complete the short version of the General Health Questionnaire (GHQ), along with some questions relating to the reason for being absent. For our study we only selected employees who: (1) wanted to participate in a follow-up by providing us with their name and contact information, (2) were still absent (completely or partially) between the period of 12 - 20 weeks after their first day of absence, and (3) had a GHQ-score of more than 5, or were completely or partly absent because of mental or psychological problems. In the latter case, an employee had to report being absent

¹ This study was performed with financial support from the Netherlands Social Security Administration (project no. 035/1998)

because of mental health problems, psychosocial risks at work (e.g., high work stress), or because of problems in his/her personal life. We included n = 555 employees in the cohort. One year later there was a valid response of n = 436 (79%).

Results 1: Reasons for reporting absent

Most respondents reported absent because of health problems. A quarter of the respondents reported that somatic health problems had been the main reason for reporting absent, whereas only 11% reported mental health problems. Another quarter reported co-morbid health problems (including both mental and somatic health problems) to be the main reason for their absence. A salient finding was that 36% of the respondents said that non-health problems were the main reason they reported absent.

Respondents were also asked to indicate which factors in the work situation or in the private/personal situation contributed to reporting absent. Leading work factors appeared to be work stress, whereas people's mental state, together with their health status, were seen as major determinants of reporting absent by the employees themselves.

Results 2: Contact with professionals throughout the sickness absence period

All employees in the cohort responded to questions about their contacts with the general practitioner (GP), the occupational health physician (OHP), and other professionals. Table 1 displays the results.

Table 1. Percentage of employees who had contacted a general practitioner, occupational health physician, or other professionals across four data collection periods

	2 months before reporting absent	First 4 weeks after reporting absent	5 weeks until 4/ 5 months after reporting absent	4/ 5 months until the end of the first year after reporting absent
General Practitioner (GP)	43.2	73.8	58.5	58.0
Occupational Health Physician (OHP)	10.8	69.2	88.8	79.8
Other professional, i.e.:	20.0	38.0	46.7	50.7
- treating psychological disorders and mental health problems	4.9	10.3	15.7	20.0
- treating musculoskeletal problems	4.1	6.1	9.7	11.2
- medical specialist (excl. psychiatrist, orthopaedist, sports physician)	7.9	15.7	15.7	20.0
- alternative professionals	3.1	4.5	7.0	7.6
- other professionals	1.6	2.7	7.4	7.1
Total number of employees	555	555	555	436

*) The percentage is the number of contacts per type of physician/professional in relation to the total number of contacts in that period per employee (n=555; n=436 from 4/5 months).

Particularly before reporting absent, 43% of these long term absentees saw their GP, whereas only 11% saw their OHP. This finding suggests that there could be a significant role for the GP in preventing employees from reporting absent. Work is not often an issue during the contacts with the GP however. In only 16% (according to employees) and 31% (according to the GP) of the contacts, work, working circumstances, and return to work were an issue.

After reporting absent, the OHP clearly takes over the role as the 'case manager', particularly when the absent period is lingering. The GP, however, stays on as a frequently consulted professional in many cases.

Other professionals are also increasingly often contacted. A salient finding is that, although this cohort was selected for reporting absent because of psychological problems, in no more than 20% of the cases at any time did the employees consult a professional who is trained to treat mental or psychological health problems.

Results 3: Predictors of work resumption

In searching for the best predictor set of full work resumption one year after the employees reported absent, we excluded all non-significant variables on the basis of univariate analyses (with full work resumption as a dependent measure). This was done to preclude multicollinearity. Table 2 summarises the results.

Table 2. Determinants that significantly relate to full-time work resumption one year after first reporting absent, as opposed to no work resumption after one year (logistic regression; only significant predictors are presented).

Variable		n	Chance work resumption	Odds ratio *)
Job insecurity	Good (ref)	310	66%	-
	Bad	126	50%	0.57 *
Depression (tertiles) (3 months after reporting absent)	M<26; W< 29 (ref)	153	72%	-
	M: 26-36; W: 29-41	141	58%	0.48 *
	M: >36; W> 41	140	52%	0.73
Depression (tertiles)	M<26; W< 29 (ref)	259	70%	-
	M: 26-36; W: 29-41	115	54%	0.45 **
	M: >36; W> 41	62	38%	0.27 ***
Private causes of reporting absent	No (ref)	329	57%	-
	Yes	101	73%	2.07 **
Contacts with GP	0 (ref)	185	69%	-
	1-2	137	60%	0.49 *
	>2	114	51%	0.44 *
Action by employer to change tasks, reduce hours etc	No (ref)	401	59%	-
	Yes	35	90%	9.25 ***

*) Levels of significance: * = $p < .05$; ** = $p < .01$; *** = $p < .001$

The main predictors of full work resumption one year after having reported absent because of psychological reasons were: (1) a sustained or increased level of serious depressive complaints, and (2) the employer being active in (temporarily) changing tasks and working times in order to get the employee back to work.

Less powerful determinants predicting full return to work were: (3) job security (less security was associated with less complete work resumption), (4) having a private cause for reporting absent (employees who report their private situation to be the cause of their absence were more likely to fully return to work; one interpretation of this is that those who report private causes for their absence are not the ones that are real long term absentees), and (5) frequent contacts with the GP (associated with long term absence). Frequent contacts with the GP may indicate that there are serious medical problems, resulting in less chance to resume work before the end of the first year of absence.

What did we learn from this study?

Apart from 11 % of the employees reporting absent because of mental health problems or psychological disorders, more than a third of the employees reported absent because of non-health problems.

After reporting absent, many employees who are at least 12 to 20 weeks absent see either their GP or their OHP; but, a relatively small group of the employees appear to see a professional who is trained to treat mental health or psychological problems, even though there is a group that remained depressed or had a high level of mental health complaints.

Work is often not an issue during the contacts with the GP (only in 16% or 31% of the cases, according to the employee or the GP respectively). It may, however, be worthwhile to find out how the GP can be more involved in work relevant issues and more supportive of work resumption.

Remaining or increasing depressive symptoms, and not so much burnout, appears to be strongly negatively related to work resumption. An additional study on the GP and OHP treating a random sub-sample of the employees followed in this study suggested that although the GP and OHP agree on the fact that the employees have mental health problems, the GP identifies burnout in cases where the OHP identifies depression, probably leading to different treatments. It was also found that they hardly ever exchange information. This situation clearly needs improvement.

The present study also shows the importance of the employer taking action, such as (temporarily) changing tasks, reducing job demands, and reducing working hours. According to the employees, only 8% of the employers do this, but such employer action was found to be associated with a 9 times larger chance of full work resumption after one year.

The study suggests some important cost saving and human grief saving interventions, related to being long-term absent with a high risk of becoming diagnosed to be disabled for work. Dutch society may improve in preventing employees from permanently leaving employment because of problems that may have been treated successfully at an early stage. Health care professionals and employers need to learn about the prevention possibilities, and start to cooperate to solve an important societal problem. This study may give some new ideas and suggestions on how and why.

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Optimal Employability

By: George Dekker and Frans Heemskerk, TNO Quality of Life

In this article we describe our method 'optimal employability in theory and practice', by illustrating the case of a consultancy project in a nursing and elderly peoples' home in The Netherlands. Consultancy is a popular instrument nowadays to implement new policies in organisations, particularly when internal communication fails or when there is a lack sufficient professional training capacity and/or financial resources. This latter nowadays is often the case in the health care and welfare sector in the Netherlands. As a result, such organisations often require assistance from external consultants.

What is Optimal Employability?

The nursing and elderly peoples' home started with two questions on the improvement of the organisation. The first question concerned the wish to upgrade the staff from a supply-oriented to a demand-oriented working attitude. The second question was to reduce sickness absence of the staff. TNO was asked to help the organisation to realise both targets. After discussing the nature of these problems with the organisation, we proposed to implement our method 'optimal employability in theory and practice', with an explicit focus on adopting demand-oriented work and reducing sickness absence.

The optimal employability method is based on two principles. The first is to create an optimal involved relationship between management and staff. This implies that the interests of the organisation and the staff are matched systematically and on an individual basis. This principle also guarantees that the balance between the workload and the work capacity of each employee is continually monitored, in order to prevent overload. The second principle is creating preconditions for an adequate working environment in the organisation. This typically involves the manager creating a working situation in which each staff member can take optimal responsibility.

Method

The optimal employability method consists of a course of four workshops for team leaders and two workshops for the management team. The management team consists of the superiors of the team leaders. Each team leader manages an average group of 25 employees in one department. We started with some preparatory work, to assess the situation in the nursing and elderly peoples' home

First, the members of the management team, the human resources (HR) manager, and a limited number of team leaders and employees were interviewed. We also collected and studied relevant documents, because it is important to pay attention to all developments in the organisation and to be aware of intervening structural and cultural influences. After this, we organised a large meeting for the management team, the team leaders, the HR manager and the employee representatives. During this meeting, a vision on employability and the role of the team leaders was developed. The slogan of the organisation was: 'Growing old in style'. This mission statement perfectly indicates the commitment of all participants with the target group they have to care for. Finally, a questionnaire was sent to all employees to measure their satisfaction with a number of aspects in the organisation.

Once all initial information had been collected, we organised the workshops for team leaders and the management team. The aim was to motivate them and to provide them with resources for managing employability and demand-oriented working. All participants learned how to communicate effectively with their staff, how to make appointments on personal development, and how to proceed towards better individual employability of staff members.

In the first workshop for the team leaders, we informed them of the results of the questionnaire survey, and the areas of employee (dis)satisfaction. Next, the team leaders were encouraged to reflect on the way they communicated with staff members. This reflection ended up in a list of topics on personal development and improving individual employability in the organisation, which could also be used in the personal employability discussions with staff members. It was clear that the topics discussed were linked to sick leave, and the potential opportunities for preventing this. We therefore encouraged team leaders to contemplate on preventive tasks during the workshops that focused on the organisation's mission and goals, and providing the nursing staff with responsibility in demand-oriented working. In the following workshops, team leaders reported back about their initial efforts in discussing employability with their staff, and received feedback to reinforce effective communication.

In the two workshops for the management team, the vision on optimal employability was discussed in relation to the objectives of the organisation. The managers also discussed their coaching methods, their own role in the organisation process, and the working conditions of the team leaders. In between the workshops, we discussed the progress with the executives of the organisation and

the HR manager, and decided with them how to proceed with the goals and contents of the next workshop.

Results

We could not assess improvements by means of direct measures, because we did not design these measures at the start of the project. We learned from the organisation that participants increasingly applied methods to advance towards a demand-oriented working attitude, and that they were motivated to continually improve on this. In former days, for instance, the nursing staff often rejected residents' requests. However, following the intervention they increasingly adopted a solution-focused attitude towards demand-oriented work.

In the evaluation meeting with the executives and the HR manager, it became clear that the workshops had a remarkable influence on the progress in the organisation, both directly and indirectly. The workshops with the team leaders and the management team had strongly influenced the vision, and the roles and responsibilities of all parties. The conditions that were necessary to allow team leaders to concentrate on optimal employability became obvious. Team leaders were able to spot (potential) problems and translate employability strategies into personal employability appointments with individual employees. Also, as a result of the team leaders meeting in the workshops, communication between departments improved, and they worked together on a common strategy.

Absenteeism dropped slightly after the project, but this was seen as a first start. It was felt that sickness absence would be combated indirectly, not with a short term working repressive type of approach, but by facilitating the employability opportunities for the nursing staff in the organisation. It was accepted that such an approach would be likely to reduce sickness absence in the long term, because the staff would increasingly feel more at ease in the organisation and use opportunities to develop. The survey on employee satisfaction was not repeated because it would have followed the first too closely, and the sector collectively developed and adopted a new employee satisfaction instrument in the meantime.

What did we learn from this study?

The company was provided with a tailor-made intervention package that could be used by team leaders and managers to facilitate the transition from a supply-oriented working attitude towards a demand-oriented working attitude. The organisation was satisfied, and we both (the organisation and TNO) ended up with a successful project.

We increasingly learn from these projects that we lack the instruments to adequately monitor progress. For instance, the employee satisfaction survey was not repeated at the end of the project, so we were unable to clearly monitor the areas where the organisation advanced or lagged behind.

We have the sickness absence figures, but we cannot predict the long-term trend of this indicator, because we do not have the information on the variables that may be related to this. Perhaps, with some minor investment, we can help the organisation to multiply the success of the project, by adding small additional and supporting monitoring instruments.

One important challenge for us therefore is how to convince organisations in the future that using suitable process and outcome indicators are worthwhile investments which pay off in the long run.

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Tripod Sigma: an instrument for pro-active stress management

By: Noortje Wiezer and Ruud Nelemans, TNO Quality of Life

Work-related stress is not only an important cause of disability and absenteeism; it can also influence an employee's performance and company loyalty in a negative way. These negative effects were recognized by a large Dutch multinational working company. In close cooperation this company and TNO Quality of Life developed an instrument, called Tripod Sigma. This instrument identifies risks related to work stress and provides tools for remedying these risks.

The Tripod philosophy

The Tripod Sigma model is developed analogous to the Tripod Delta model which the company has initiated to identify and pro-actively control safety risks. The main philosophy behind Tripod Delta is that human error can most effectively be controlled by controlling the working environment and the organisation of work. Work stress, like human error, is something that becomes visible on the level of the individual. Although work-related stress involves the mental and physical state of an individual, a 'sound organisation' is the best way to prevent it and to guarantee an optimal performance.

The participating company considers work-related stress a prominent health risk. They asked us to develop an instrument that would emphasise management responsibility in dealing with this problem and that would inspire and tempt managers to take appropriate action.

Difficulty in combating stress with traditional methods

To successfully reduce stress risks, management action is needed. However, stress is usually not high on the priority-list of management. Most stress reduction programs simply result in advice, often not (or just partly) being followed up.

An important reason for this is that, generally speaking, management actions are focused on targets related to company profits, labour productivity, quality of output and (in the case of our company) safety issues. To motivate managers to take action on issues concerning work-related stress, a strong link with the issue mentioned above is important. When it is made clear that work-related stress endangers their main targets and in what way, a sense of urgency is likely to occur. Furthermore, it is important to present managers with some clear cut actions that they can take to improve the situation.

Both elements (making clear productivity risks and solutions) are often absent in the stress surveys that are generally used in the Netherlands and the English literature. Tripod Sigma was developed to do just that. The focus of attention is on the primary process, and causes of work-related stress are presented as flaws in the primary process. Besides that, the problems on the shop floor are also linked to actions taken by management. This enables management to pinpoint actions they themselves can take. Tripod Sigma provides them with the most efficient way of optimising organisational effectiveness, and to do that in a way that also has a positive effect on the work-related stress experienced by their employees.

Approach

In Tripod, the environmental conditions that cause human error or work-related stress are called 'latent failures'. These failures are organised into so-called Basic Risk Factors. What is measured with a Tripod survey is the level of control an organisation has over each Basic Risk Factor. The survey results show whether there are deficiencies in the business process and where these deficiencies are. By remedying these deficiencies, management can prevent human error or work-related stress and business upsets.

Results

We translated these thoughts on Basic Risk Factors and deficiencies in the business process into one comprehensive user questionnaire. This questionnaire was then administered in three plants of the company worldwide. Statistical analysis of the results of the three pilots validated the Tripod Sigma model and the survey instrument based on the model. All pilot studies showed the usefulness of translating a complex concept like work-related stress into a comprehensive set of manageable issues. It made it easy for management to see what action they should take to optimise their organisation.

What did we learn from this study?

In the first place, the company was provided with a tailor-made and appropriately working instrument. The introduction of control options and cultural values, offered the participants a much broader view on how to solve problems and invest in preconditions that should be met to

successfully do so. Tripod Sigma is now being offered to all company plants and supplying organisations outside the company to pro-actively control stress risks.

This project confirmed our view that the application of current work-related monitoring instruments offers a poor solution when indications for intervention are wanted. These instruments are almost always developed for comparing a broad range of working situations and provide us with a non-specific overview of general risks. When applied in organisations, the user has to translate conclusions on risks into suggestions for change and intervention. The new Tripod Sigma instrument advances on this and gives indications for specific action.

We believe that organisations and sectors are increasingly in need of such instruments, now that the urge for interventions increases and becomes more real. Monitoring risks and generating suggestions for improvement is a developing trend, certainly stimulated by instruments such as the Balanced Scorecard and the EFQM model. We have learned that instruments (or parts of instruments) such as Tripod Sigma are basic to the continuous improvement cycles of organisations in their search for excellence. With this project we hopefully contributed to this development.

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Epilogue

By: John Klein Hesselink, TNO Quality of Life

We all are proud of our institute as one of the important players in Dutch society on innovation in work-related issues. As such, we contribute in solving many societal and technological questions. Occupational Health Psychology is one of the disciplines we apply. However, we know that in society material problems tend to dominate and that psychosocial and (mental) health problems are often neglected. Our three contributions illustrate that many employees suffer unnecessarily because there may be inadequate attention paid to their problems; but also that there are organisations that care about these issues, and that ask for solutions. By making visible the needs of employees in complex work environments, and by presenting some methods to improve this situation, we hope to inspire employers and employees (including their representatives) on the one hand, and researchers, consultants, and other professionals working in the field of Occupational Health Psychology on the other hand, to contribute further to the solution of these problems.

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Occupational Health Psychology in Japan

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In this short report I will describe the state of the art in the field of occupational health psychology in Japan. Over the last decade, we have seen major changes to the work environment affected by the economically hard times we have experienced since the early 90s. Through the enduring recession, rapid and diverse changes have taken place in almost all organizations irrespective of private and public sectors. Those changes include restructuring, downsizing, M&A, and abandonment of traditional seniority and life-employment systems, which have been thought to be unique to Japan and regarded as key systems leading to a miracle recovery of Japan's economy after World War II. Furthermore, we are now facing global competition and the IT revolution. As a consequence of those drastic changes, employers as well as employees have felt much more stress at work. Also, as the number of career-orientated working married women has increased, not only men but also women feel stress at work. As men have to take a new role and responsibilities of sharing housekeeping and child care, they often experience role conflicts at home. Those changes have caused a greater tension between spouses at home. Accordingly, home, which was originally working as a strong buffer against stress at work, no longer provides an oasis for male workers.

More stressors and less support in the workplace have led to increases in employee stress and mental disorders. For example, the number of officials of local governments who took sick leave over one month due to mental disorders has increased almost 50% over the last five years. In addition, the number of suicidal cases has remained over 30,000 for the last six years, a 35% increase compared with the previous years. A new word, 'Karo-jisatsu' i.e. a suicide attempt due to over work, was created in 1997. In a civil case, one of Japan's ad companies paid over one and half million dollars to 'karo-jisatsu' victims' parents. Thus, we are facing a grave condition in the field of occupational mental health. Furthermore, it seems that the young workforce is getting more vulnerable to stressors in general. Some withdraw from society and become 'NEET' (not in employment, education, or training). They tend to avoid any conflicts at home, at school, in the community, and in the workplace. The vulnerability among young people is another serious issue in contemporary Japan.

In 1999, the Japanese government published a guideline on compensation for employees who commit suicide or who suffer from mental disorders due to work stress. The government employed a stress-vulnerability hypothesis for the recognition process. Based on that hypothesis, they assess three factors; stress at work, stress in other areas, and the employee's vulnerability. When stress at work is prominent and the other two factors are less important, the index employee can be recognized as suffering from a work-related mental disorder and can be compensated for the

loss he had. When factors other than work stress seem to contribute to mental disorder, they will make a judgment based on two professionals' comments. They are requested to decide the index case as being work-related or not.

As a countermeasure against the serious mental health issues at work, the Ministry of Health, Labor and Welfare published a mental health guideline for the workplace in 2000. The guideline stressed four kinds of care providers for employees. Thus, care providers consist of four categories, i.e.

(1) 'self-care', (2) 'care by line managers', (3) 'care by occupational health professionals' in the workplace, including occupational physicians, occupational psychiatrists, occupational health nurses, counselors, and (4) 'care by off-workplace providers' including EAPs. Also, the guideline mentioned about the contents of mental health services which consist of three main activities, i.e. (1) improvement of the workplace environment including psychological as well as physical environment, (2) psychoeducation targeted at employees, in particular managers, and (3) helpdesk inside and outside the workplace. The guideline gave employers an incentive to start or strengthen their mental health promotion activities. Many employers have set up a mental health care systems in their workplaces following the guideline.

Concerning professionals in the workplace, the Labor Standard Law in Japan states that at every workplace where over 50 employees work, there should be an occupational physician. Furthermore, when the number of employees exceeds 1,000 in each site, an employer must hire a full-time occupational physician. In the past, most employers hired physicians or surgeons who retired from hospitals and started a second career. However, recently employers have realized that psychiatrists are very important because psychiatric cases have been increasing and case management of those employees has become a big burden for employers. Aside from occupational physicians, we have occupational nurses, occupational counselors, and health managers. These professionals work together as a mental health team where a psychiatrist plays a significant role as a team leader.

We have several serious problems when we try to implement a mental health system in each organization. One of the critical problems is the small number of professionals in this field. We have now about 10,000 psychiatrists in Japan. It is estimated roughly that about 10% of psychiatrists are involved in workplace mental health services. Furthermore, we have about 10,000 certified clinical psychologists and 15,000 certified occupational counselors. While clinical psychologists are not much interested in a work environment, occupational counselors do not have enough skills to assess mental state properly. The number of mental health professionals is however rapidly increasing, which reflects the growing need for mental health solutions in the workplace.



Professor Satoru Shima addresses delegates at the 2004 EA-OHP conference in Oporto.

Thus, the present situation seems to give us a challenging opportunity for more mental health professionals to get involved in the workplace.

We have developed two instruments supported by the Ministry of Health, Labor and Welfare. One is an individual self-check system, usually on-line, and the other is a stress map which assesses organizational stress. These two instruments are now widely used across Japan. The self-check system is very practical for improving awareness of stress and mental health and is cost efficient, so this system can be used as primary and secondary intervention measures. The stress map has been used for management education on organizational stress, mainly occupational stressors and social support.

Although there has been a continuous warning on the relation between long working hours and employees' health, actual working hours have not been shortened. At the end of 2001, the Ministry of Health, Labor and Welfare published guidelines on working hours in relation to compensation of sudden death due to cardiovascular diseases. The guideline says that if an employee who died of cardiovascular diseases worked over 100 hours in the last month or over 80 hours on the average of the last 2 to 6 months in terms of excess work, he or she would be recognized as a work-related death. While this guideline was originally designed for cardiovascular diseases, it will be applied to mental disorders, especially in a civil case.

I recently contributed to a research project on better utilization of off-workplace resources including EAPs. In the project, we assessed how various resources were used. Resources consist of psychiatric hospitals and clinics, occupational health promotion centers, regional occupational health centers, mental health and welfare centers, and counseling centers. We also assessed mental health care systems in the workplace. The results showed several points. One is that many employers are now interested in mental health services and some of them have already established a system, although some systems are immature and do not function well. While large companies generally have a mental health care system, small and a medium sized companies do not. Mental health care activities include help-desk inside or outside the workplace, psychoeducation targeting HR personnel, managers and other employees, self-check system, networking with resources outside the workplace in an interactive way, crisis intervention team, annual individual mental health check and organizational stress check, and management consultation. In general psychiatrists and counselors who work outside the workplace do not know much about working conditions, nor are they much interested in issues in the workplace.

At present, return-to-work is a big issue in Japan. There are several reasons. Since Japanese workers have been long accustomed to a life employment system, they think return-to-work in the same workplace is a natural expectation. In the midst of ongoing restructuring and lay-offs, though, most companies do not want to accept return-to-work employees. Since job demands tend to increase after a restructuring, return-to-work has been getting much harder. Furthermore, rapid change in workplace duties has made adaptation of back-to-work employees more difficult.

The Ministry of Health, Labor and Welfare has therefore provided funding for return-to-work problems, mainly focusing on depression. Although psychiatric rehabilitation programs are available

in this country, all of them are designed for schizophrenic patients. We are now planning rehabilitation program for depressed employees, partly in the context of job rehabilitation.

Last year I conducted a survey in order to estimate the social loss caused by sick leave, and to gather information on current return-to-work systems in each organization. A questionnaire was administered to over 2,000 companies. The results showed that the estimated loss is around ten billion US dollars per year. In some organizations, the rehabilitation process can be successfully provided to a back-to-work employee. However, that kind of process is in general not well systematized, nor clearly stated. It is recommended that an employer should provide well organized and employee-friendly systems to minimize the loss caused by sick leave, and to actualize a win-win result for an employee, an employer, and all other stakeholders.

This brief report has described recent developments in the field of occupational mental health in Japan. I hope more and more mental health professionals will get involved in this field. We established the Japan Society for Occupational Mental Health (JSOMH) about a decade ago. We now have about 800 members including psychiatrists, occupational physicians, clinical psychologists, occupational counselors, occupational health nurses, IO psychologists, and HR personnel. JSOMH looks forward to exchanging information and ideas with the European Academy of Occupational Health Psychology.

Acknowledgement

I deeply express my gratitude to Paul Flaxman for giving me this opportunity to correspond with members of the European Academy of Occupational Health Psychology

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- Discounted individual subscriptions to the Academy's affiliated journal, *Work & Stress*. The journal is an international, multidisciplinary quarterly presenting peer-reviewed papers concerned with the psychological, social and organizational aspects of occupational and environmental health, and stress and safety management.
- The Academy's electronic newsletter, the *Occupational Health Psychologist*, three times per annum.
- Voting rights to shape the discipline of occupational health psychology through the EA-OHP.

Research Reviews

In this section we review and summarise a number of recent OHP research articles. Please contact the Editor (Email: P.Flaxman@gold.ac.uk) if you come across a research article that you think should be summarised in this section, or if you would like to see a review of one of your own recently published research articles.

DOES LEADERS' MOOD INFLUENCE THEIR SUBORDINATES PERFORMANCE?

Mood contagion is a mechanism that induces a congruent mood state through the observation of another person's public display of mood. The basis for this research is the tenet that past studies have not directly investigated whether leaders transmit their moods to other group members; influence group affective tone and influence group processes (coordination, effort expenditure and strategy) through mood contagion.



Sy, Côté and Saavedra conducted research with 189 students from three undergraduate courses in the United States. Using an experimental design, groups performed a task while leaders' mood was manipulated to be either positive or negative. Mood was assessed using the 'Job Affect Scale'. Group affective tone, group processes and group performance were calculated.

In summary, the authors conclude that:

- Moods of leaders are transferred to other group members.
- The moods of leaders influence two group processes (effort expended and task coordination) that are critical to group effectiveness.
- Displayed moods communicate goals, objectives and attitudes to other people.

The underlying notion in this article is that leaders' moods can be powerful forces within groups. Knowledge of the consequences of leaders' moods can improve the prediction of group processes. Affect is considered in models of leadership as it is increasingly accepted as an important factor contributing to the performance of organisations.

Sy, T., Côté, S. and Saavedra, R. (2005). The contagious leader: Impact of the leader's mood on the mood of group members, group affective tone, and group processes. *Journal of Applied Psychology*, 90(2), 295-305.

DOES PERSONAL CONTROL BUFFER AGAINST THE STRAIN OF REGULATING EMOTIONS IN THE WORKPLACE?



People engage in emotional regulation because it contributes to obtaining desired outcomes. Response-focused emotion regulation refers to modifying behaviour once emotions are experienced by suppressing, faking or amplifying an emotion response. Grandey, Fisk and Steiner's purpose was to examine whether the extent of personal control buffers against the depletion from emotion regulation. Two indicators of personal control are job autonomy and emotional culture.

Effects of control as moderators of the strain of emotion regulation were tested in 196 participants from two cultures (US and France) that varied in their orientation towards emotions. Using a survey design, measures of response-focused emotion regulation, job autonomy, emotional exhaustion, job satisfaction and negative affectivity were collected.

The authors found that:

- Employees in more impulsive cultures were less likely to suppress or fake emotions to follow institutional norms, and instead did it by choice.
- When employees believed they had autonomy in job behaviours, emotion regulation that was otherwise exhausting was not associated with exhaustion.
- Having control over their emotion regulation reduced job dissatisfaction.

In brief, employees who frequently engage in response-focused emotion regulation with customers and have low job autonomy are at risk for burnout. With the current global economy, cultural differences in work emotions are important to understand. Managers need to be aware of the potential strain on employees if they require emotional displays that are incongruent with cultural norms.

Grandey, A.A., Fisk, G.M. and Steiner, D.D. (2005). Must "Service With a Smile" be stressful? The moderating role of personal control for American and French employees. *Journal of Applied Psychology*, 90(5), 893-904.

LAY REPRESENTATIONS OF STRESS AT WORK

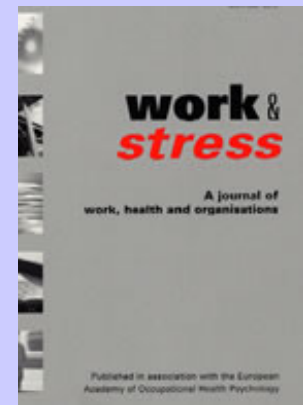
Kinman and Jones examined lay representations of work stress in an occupationally heterogeneous sample of 45 working adults by using semi-structured interviews. Previous research has predominantly examined work stress from a manager's perspective, and one aim of the study was to investigate representations of work stress held by those with no line management responsibility ($n = 25$). Some evidence suggested a difference between these two occupational statuses:

individuals with line management responsibility were more inclined to emphasise individual responsibility for managing stress in contrast to the structural approaches favoured by lower grade employees.

Similarly to research investigating lay theories of other psychological phenomena, Kinman and Jones found that representations of occupational stress were not naïve beliefs about cause and effect, but sophisticated and multi-faceted. Parallels were apparent between lay representations and theories of stress from the scientific literature. The most common definition of work stress from the sample referred to it in terms of an interaction or transaction between the individual and environment. The sample also perceived work stress as both positive and functional, and a negative feature of work, which is contrasted with the prevailing view in the literature of stress as a wholly negative concept.

The causes of work stress were seen as predominantly organisational, however secondary and tertiary stress management techniques were thought to be more effective than primary interventions designed to prevent work stress.

The authors suggest many advantages to studying lay representations of work stress, for example, enriching stress audit data to provide an insight into the stress culture of an organisation, together with attitudes towards different stress management strategies.



Kinman, G. & Jones, F. (2005). Lay representations of workplace stress: What do people really mean when they say they are stressed? *Work & Stress*, 19(2), 101-120.

DO ORGANISATIONAL CHANGES CORRELATE WITH CHANGES IN HEALTH CONDITION OVER TIME?



Petterson *et al.* examined Swedish healthcare professionals over an 8-year period to study trends in health and work conditions in an ecological study. This timeframe was characterised by personnel redundancies and a restructuring process. Staff responded to questionnaires on five occasions from 1994 to 2001, and this data was used as aggregated means on the departmental level. Organisational-level data was also examined, for example short- and long-term sickness absence. It was hypothesised that work environment changes on the work-unit level would have an impact on the unit's employee health.

Negative trends in mental health and in long-term sickness absence were found, whereas the level of short-term sickness absence was found to be stable over time. The increasing demands of working hard, conflicting demands, and lack of time to plan the work were

strongly associated with deteriorating self-rated health. The association between the increasing working hard trend and diminishing proportion of nursing staff is regarded as support for the hypothesis that nursing tasks must be performed by other professionals in addition to their regular work.

Decreasing time to plan work showed the strongest association with increasing long-term sickness absence. Lack of time to plan work mostly means producing under time pressure, referring to a lack of control over both quantitative and qualitative demands. Lack of work social support was also a risk factor for short-term sickness absence.

The study did not allow causal inferences to be made about the relationship between the trends of work and health, however associations between the two were confirmed. Overall, the results support stress as a precursor of ill-health. Importantly, the data suggest short- and long-term sickness absence are separate phenomena, and should be treated as such in health research.

Petterson, I., Hagberg, L., Hertting, A., & Theorell, T. (2005). Are trends in work and health conditions interrelated? A study of Swedish hospital employees in the 1990s. *Journal of Occupational Health Psychology, 10*(2), 110-12.

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Please find below general guidelines for submitting articles for future issues of the *Occupational Health Psychologist*. We hope that our willingness to publish many different types of articles will encourage all of our members to contribute. We welcome articles from students, new researchers, practitioners, and from long standing members of the Academy. Three issues per year will be published: February/March, June/July, and Nov/December.

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OHP Briefings

We also welcome overviews of your OHP-related activities, or those of your research group, consultancy, or organisation. We believe that this type of article will provide a useful insight into the sort of work that is being undertaken in different parts of Europe. This section could also be used to communicate policy developments that have implications for OHP research, practice, and education in your country. This type of article should generally be about 2000 words, although we will accept longer articles if more than one member of a group wishes to contribute (as with the TNO articles in this issue).

Other articles

We also welcome news items, open letters to your fellow occupational health psychologists regarding any OHP-related topics, and summaries (in English) of OHP issues that have been reported by your national news media.

**Please email your articles to
Paul Flaxman at P.Flaxman@gold.ac.uk**

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