T Cox et al. HSE Research Report RR449 (2006)
Defining a case of work-related stress

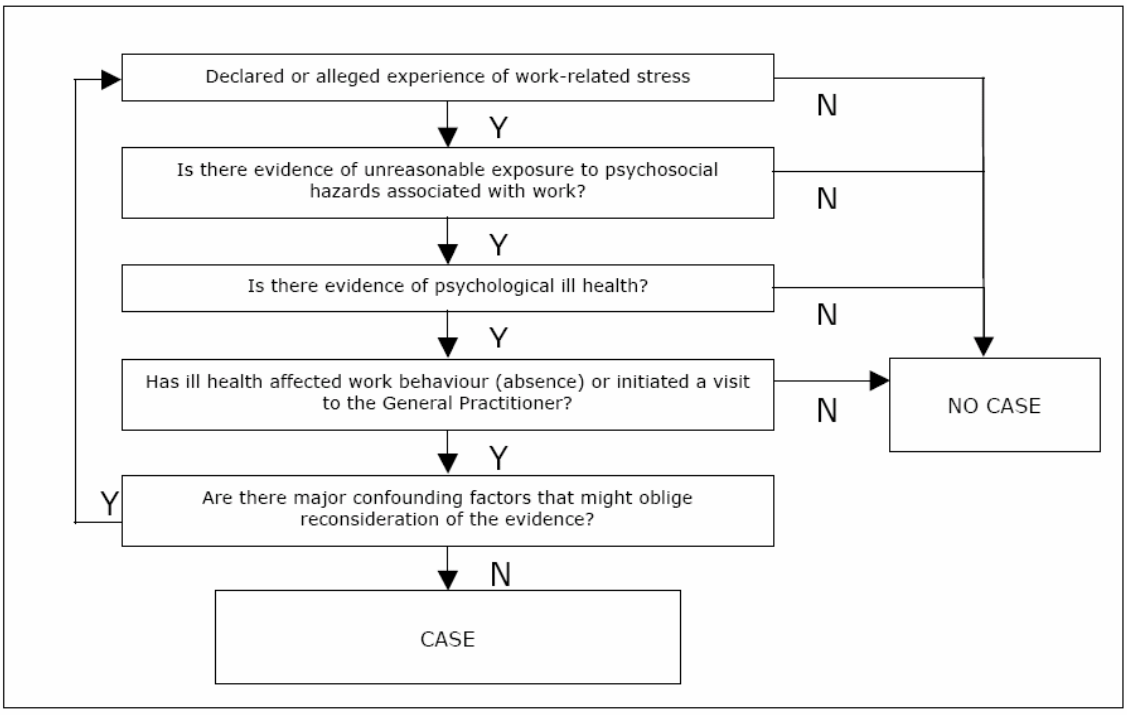
The research aimed to develop a commonly agreed framework for the determination of a case of work-related stress. The framework would primarily be used for research work but it was hoped that it could also be used in occupational health and compensation. In our view, the framework is generally applicable but actual validity depends on the specification of the tools used and the assumed thresholds. It seems highly unlikely that a single set of tools and thresholds would be of general validity. In our view, expert (not GP) assessment is required for occupational and compensation-related determinations, but these could follow the framework suggested here.

There is no commonly agreed method for determining either a case of work-related stress [where work is one of many factors affecting perceptions or adverse outcomes] or occupational stress [where stress at work is the sole cause of adverse outcome]. The methods often used by researchers are usually highly unsatisfactory and have led to much uncertainty as to the meaning of research and its policy and compensation implications. A commonly agreed method of case determination would allow more accurate analysis of conditions at work, and may one day lead to the identification of significant health [as opposed to well being] risk factors. It could also help increase the accuracy of medical and medico-legal advice.

The reported aims off this research were 1) to identify a case definition of work-related stress for use in epidemiological research (into causes, effects, prevention, diagnosis, prevalence, incidence etc.) and 2) to identify a case definition for use in the occupational health setting. The primary aim was aim 1). HSE have been set clear targets for the reduction of the incidence of work-related stress but as yet have not been able to establish a robust method of measuring it.

Among the key areas of uncertainty in defining cases of work-related stress is the degree of response to the work environment that is sufficient to be of interest. Some researchers want to know how much psychiatric damage is being done by work conditions, others want to measure the general mood of dissatisfaction. The purpose to which the case definition will be put is crucial to the utility of that definition.

The following figure describes a logical process for identification of a case of work-related stress. The order of the steps may be unimportant, the degree of objectivity required, the agreed definitions and thresholds at each step will be crucial to the utility of any given scheme of assessment.

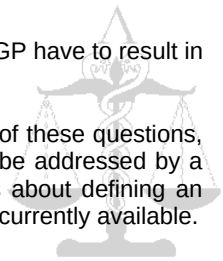


Key questions for the proper use of this framework are:

- What is unreasonable exposure to psychosocial hazards associated with work? What is a psychosocial hazard and would this universally be perceived as a hazard? What degree of exposure is unreasonable, are exposures additive are they additive in the same way for everyone? Are reports of exposure subject to political intent?

- What kind of evidence of psychological ill-health would be sufficient, e.g. irritable mood or psychiatric diagnosis?

- Is it ill health that affects work behaviour or is it illness. Does the visit to the GP have to result in a recognised diagnosis?



It is possible that there are robust epidemiological tools that can be applied to each of these questions, however, it may be that an element of judgement is required. These questions will be addressed by a later report dealing with tool selections and case thresholds. The present report is about defining an assessment framework, though it provides an extensive analysis of the tools that are currently available.

It is also essential to ensure that any method of divining the contribution of work factors to the stress experience enumerates the difference between aggravated by work [i.e. work-related stress] and caused by work [i.e. occupational stress]. This will affect the interpretation of epidemiological studies and illustrates a key difference in the reasons for studying stress; for example, those who want to measure the full cost of exposure to work stressors to society vs, those who seek compensation. HSE are, officially, tasked with reducing work-related stress, not specifically occupational stress. In our view, these are numerically very different aims that unfortunately may be readily confused with each other.

The report provides a historical view of the development of stressor identification including the demands-control model, the efforts rewards imbalance model, and the transactional model (where the individual meaning of the exposure is recognised as the mediator of the stress phenomenon). The latter model is favoured by the authors of the research report, and meets the approval of this reviewer. It does however, present difficulties to those institutions that seek objective proof of hazardous exposure. These people will prefer a 'list of hazards' approach to stress risk assessment and case identification. In our view, this 'list of hazards' approach is more practicable and manageable, but is more than likely irrelevant to individuals. It is individuals, not work groups who seek compensation. The former approaches have been useful in identifying and characterising factors which could be problematic for groups of people but have, in our view, been severely limited in scope. Perhaps these limitations are among the reasons why group stress interventions don't work and why there are few clear relationships between exposures and objective medical outcomes. One of the expert panel asked to validate the assessment framework pointed out:

> *"Stressors are not stressors unless they are interpreted as such by the exposee. However, the awareness of a potential stressor and its interpretation by individuals and groups are potentially conditioned responses. In that respect, self report is potentially unreliable. Self report should be corrected for factors (innate and environmental) which would influence 'tendency to report'. This correction may be possible at the group level, and perhaps at the individual level, but confidence in this correction would usually be moderate at best, e.g. negative affectivity is determined by self report!!."*

The report notes that if ever there is to be specific regulation of stress at work, for the purposes of protecting health, then there will need to be an agreed definition of a case of work-related or occupational (depending on the purpose of the regulation) stress. Without such a definition there could be no identification of the victims of the breach of statutory duty.

The report notes that in principle, civil cases can succeed if work stressors have aggravated ill health (made a material contribution); success is not, by definition, limited to those cases where work was the sole cause. In this respect, people with undeclared vulnerabilities could succeed in a claim even if the employer had no means of knowing of the vulnerability. The authors cite *Page v Smith* [1996] in support of this argument. The case reinforces the "take the victim as you find him" principle. In practice, the courts set a high hurdle for proof of foreseeability.

The report also questions the validity of requiring proof a clinical diagnosis in finding for the claimant. Stress is not a recognised diagnosis yet people who are stressed are often suffering very real detriment. It has not proved possible to convince the courts that physical diagnoses are the result of exposure to stress. The authors assert that the proposal that stress causes coronary heart disease has a great deal of scientific validity. This reviewer does not share that interpretation of the available evidence.

[There are strong indications that psychiatric diagnoses will one day adopt a non-threshold approach; i.e. there will be no thresholds, only degrees of diagnosis. Such an approach, if officially adopted by

WHO for example, would significantly reduce the barriers to a successful claim, unless the courts decided that a threshold approach was the only manageable approach. Without thresholds, claimants would only need to demonstrate some degree of psychiatric impairment as a cause of action, and could point to an official WHO diagnosis in support of their claim. Whether that was a sufficient impairment to warrant financial indemnity would be a matter for the judge to decide]. One of the expert panel asked to validate the assessment framework pointed out:

> *"If a survey tool is to be valid, it must rely on valid outcome measures. Use of mild mental ill health as an outcome would add considerable uncertainty to the interpretation of any research findings…There is a duty to protect people from preventable ill health not to protect them from feelings of a lack of well being, fatigue or disappointment."*

The requirement for a clinical psychiatric diagnosis no longer applies to claims under the Disability Discrimination Act (1995). The DDA would punish those who do not make reasonable adjustments to accommodate those who suffer disability e.g. failings of memory, or ability to concentrate, learn or understand. [But what exactly is a reasonable adjustment? There is no clear guidance available as to the likely effectiveness of any adjustment to correct for such disabilities. If an adjustment doesn't work is it by definition an unreasonable one?].

There are no diagnoses that are specific to work stress and no work places or work types that have been shown (scientifically) to double the risk of any particular diagnosis. These are the principal reasons that there is no access to Industrial Injuries Disablement Benefit.

Comment

The approach suggested in the above figure seems a reasonable one for epidemiological research. It is, in our view, more robust than previous survey methodologies. If the discussion provided in the report is used to define the actual form of the survey tool, the number of cases of work-stress related ill health would be found to be considerably lower than current estimates based on questions such as '*Are you experiencing stress in relation to your work*?'.

Without detailed specification of the tools to be used at each stage, and the thresholds to be adopted, it is not possible to state the relevance of survey findings to potential liability exposure.

On an individual case level, the approach could be adapted to the assessment of individuals provided the assessor was an expert, not a GP. A tool could be developed for the purposes of medico-legal assessments, based on the suggested framework.