Treating Work Stress: An Alternative to Workers' Compensation

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Work stress is a growing and expensive problem. A model for group psychotherapy for disgruntled workers presenting with psychiatric symptoms was offered through Kaiser Permanente's outpatient psychiatry department. The findings of a 2-year follow-up study conducted on group participants indicate that this type of cognitive-behavioral group psychotherapy can be helpful in increasing employee satisfaction and adjustment at work. This also raises the possibility that early intervention through group psychotherapy may be effective in reducing the incidence of workers' compensation stress claims.

Work stress has been a growing concern since the late 1980s. Business and industry are distressed about the spiraling costs of work stress, which are estimated at $150 billion annually as measured by lost productivity and workers' compensation claims.[1] The California Workers' Compensation Institute has determined that stress claims increased 700% from 1979 to 1988, and that most mental stress claims result from cumulative events rather than from a single incident. Virtually all (98%) claims are litigated, with the average cost of settling a mental stress claim averaging $12,000.[2] Although California has the most liberal standards for workers' compensation stress claims, 17 other states, including Michigan and New York, compensate workers for mental stress. Levi points out that the National Institute for Occupational Safety and Health lists psychological disorders among the ten leading work-related diseases or injuries.[3] He reported to the World Health Organization that almost 75% of patients seeking psychiatric consultation have difficulties with job satisfaction and stress.[3] Sauter et al stated that work stress is second only to loud noise as the most pervasive, hazardous work condition.[4] They cite a study by the National Council on Compensation Insurance which showed that the costs of workers' compensation for gradual mental stress surpassed the average cost of claims for all other occupational disease in the period from 1981 to 1982. Among various methods for preventing work-related psychological disorders, they call for "surveillance of

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psychological disorders and risk factors."[4]

Clearly, we need to find ways to ameliorate work stress for humanitarian as well as economic reasons. Given the enormous costs currently involved in workers' compensation, it is important to ascertain whether we can reduce workers' compensation claims by offering early treatment. Warshaw advocates offering education or training to increase the coping capacity of individuals who are at risk either because of their own vulnerability or their exposure to high levels of stress at work.[5] Likewise, Felton maintains that early identification and referral to counseling can both enhance work performance and lower the incidence of psychiatric injury claims.[6] This is the rationale for most employer-sponsored employee assistance programs.

Brodsky proposes a treatment model for workers who are suffering from harassment or work pressure, which begins with ventilation of feelings and moves on to help troubled workers develop a support system, realistically examine the alternatives, and look at their own role in the difficulty.[7] Mor-Barak also emphasizes the importance of social support in moderating the impact of occupational stress and goes on to cite empirical evidence that correlates lack of social support with disease.[8] McLean gives case examples showing the successful treatment of individuals who complained of stressful changes at work.[9] Handron and Thomas describe a program in which the EAP can refer an employee experiencing stress for short-term counseling at the employer's expense.[10] The average cost of such treatment was $150 per case, whereas the employer's workers' compensation stress-claim reserve was reduced from $237,795 to $90,000 in a 2-year period.

More recently, authors such as Corey and Wolf and Kirschman et al have proposed organizational interventions that can reduce employee stress.[11,12] Stress-management training has been popular,[13] yet stress-management training frequently offers little more than a palliative, and most organizations are unwilling to invest the resources—either in terms of direct costs or workers' time—to effect organizational interventions. The need for accessible treatment for the individual who is experiencing stress at work seems clear.

The department of psychiatry at Kaiser Permanente, a large health-maintenance organization (HMO), have long been concerned with the high volume of crisis patients presenting with complaints of work stress. To address the needs of this patient population, as well as to address the cost-containment needs of our larger corporate customers, Kaiser South San Francisco's Department of Psychiatry developed a work-stress prevention group.

Methods

The work-stress group began meeting weekly in the Kaiser South San Francisco outpatient Psychiatry Department in the fall of 1990. Before being accepted into the group, all participants were evaluated by a licensed mental health professional (psychiatrist, psychologist, or clinical social worker) for recording of patient history, determination of a psychiatric diagnosis, and assessment of the need for psychotropic medication. Those patients with substance-abuse problems were screened out at this time and referred to a separate program for chemical-dependency treatment. Patients who were psychotic or actively suicidal were not accepted into the group, although many participants met the criteria for personality-disorder diagnoses.[14] Because the purpose of the group was to provide an alternative to worker's compensation, a group leader screened each applicant to determine their willingness to seek a nonlegal solution to their work problem and provide orientation to the group. Although an agreement not to file workers' compensation claims was a requirement of group membership, over 80% of those patients screened were willing to try group treatment in lieu of filing a claim.

Sixty-two patients participated during the 2-year-period studied (January 1991 through December 1992). The group averaged seven participants, with a maximum enrollment of ten members. During the period studied, the group was predominantly female (45 female, 16 male) and Caucasian (33 Caucasian, 11 Asian, nine Hispanic, eight African American). Participants' ages ranged from 25 to 61, with a majority (35 members) between 30 and 49 years of age. According to the Hollingshead-Redlich Four-Factor Index, ten group members held jobs in Category 2 (managers, lesser professionals), 22 in Category 3 (administrators, small business owners, semi-professionals), 22 in Category 4 (clerical workers), five in category 5 (semi-skilled workers), and two in Category 6 (unskilled workers) (Hollingshead AB, Four-Factor Index of Social Status, unpublished manuscript, 1975). These demographic data compare with California Workers' Compensation claimants in general. According to the California Workers' Compensation Institute (1988 and 1990), female employees file twice as many stress claims as their male counterparts. Most claimants (63.1%) are in the 30-to-49-year age group, and 40% work in sales or clerical jobs.

The group was open-ended, with new members joining as openings arose. Participants could stay until they reached the limit of their psychiatric benefit (20 sessions for most participants). A few members with special coverage came for more than 20 sessions. The number of sessions attended ranged from one to 40, with a mean of 12 and a modal number of nine visits.

Participants presented with three general problems: (1) interpersonal problems with a boss or coworker, (2) excessive work load, and (3) organizational change. Two participants who came into the group after

experiencing a single trauma, such as being mugged, felt they had little in common with other group members and stayed for only a few sessions.

Treatment followed a cognitive behavioral model. The most effective interventions appeared to be group support, education, practical problem solving, and stress management. The agreement to try group treatment before deciding to file a workers' compensation claim was considered to be a treatment intervention in itself, as this decision facilitated the patient's shift from an adversarial attitude to a problem-solving one. Group members were encouraged to contribute to a collective scrapbook containing articles on work stress, resource information, inspirational messages, and cartoons. Most group members eventually came to understand that they were unlikely to change their companies, such as the federal government or major banks and utility companies, but did have the power to change their attitudes and ways in which they dealt with their workplaces. This concept became part of the group culture and was passed on to newer members by members who had been in the group longer, who advised them to "look at your 50% of the problem."

A follow-up questionnaire, with a self-addressed stamped envelope, was sent to all 61 known surviving patients who participated in the Work Stress Group during the 2-year period from January 1991 to December 1992. The questionnaire asked:

1. Are you still working? If yes, are you at the same job? If you are not working, are you satisfied with your situation?
2. How do you feel about your work compared to when you started the Work Stress Group?
3. Have you considered filing for worker's compensation, either before or after attending the group? Did you file a worker's compensation stress claim?
4. What did you learn at the group that has been helpful?

TABLE 1
Study Group Demographics

Parameter	Respondents	Nonrespondents
Mean Number of Sessions	14.08	8.29
Race		
Caucasian	26 (65%)	5 (25%)
African American	3 (8%)	5 (25%)
Hispanic	3 (8%)	5 (25%)
Asian-Filipino	5 (13%)	3 (15%)
Asian-Other	3 (8%)	1 (5%)
Job Type		
Class 2	7 (18%)	3 (15%)
Class 3	16 (40%)	5 (25%)
Class 4	15 (38%)	8 (40%)
Class 5	1 (2%)	3 (15%)
Class 6	1 (1%)	1 (5%)
Gender		
Male	10 (25%)	6 (30%)
Female	30 (75%)	14 (70%)

Results

Forty responses were received from 60 questionnaires sent out to surviving patients. Two additional members had died since participating in the group. One had succumbed to the cancer she had while participating in the group (not surveyed); the other, a 40-year-old woman, had a fatal heart attack after she dropped out of the group, claiming she was too busy at work to participate (response returned by her husband). Nonrespondents were similar to respondents in terms of gender (Table 1) and job type, but differed significantly terms of race and number of sessions attended. Nonrespondents had attended a mean of eight sessions (with 67% having attended six or fewer sessions), whereas respondents had attended a mean of 14 sessions (with only 24% having attended six or fewer sessions). The modal psychiatric diagnosis for both groups was DSM-IV Axis I: 309.0, Adjustment Disorder with Depressed Mood; Axis II: 301.9 Personality Disorder Not Otherwise Specified.[14]

The results of the questionnaires are summarized as follows (Table 2): Thirty participants (75% of the respondents) reported that they felt better about their work since attending the Work Stress Group. Twenty-four of these participants (75%) still had the same job. Of the seven respondents who reported that their attitudes were unchanged, four still had the same job whereas three had moved on to other life situations (retirement or unemployment). The one person who reported feeling worse about her work had attended the group only twice and had dropped out to file a worker's compensation claim. Among the respondents, there did not appear to be a correlation between improvement in attitude and length of time in the group.

Ten respondents reported that they had considered filing a worker's compensation stress claim before they came to the group. After group participation, only five patients were still considering worker's compensation. Only two of these patients actually filed claims, whereas a third was absent from work because of disability. We learned that one additional participant, who did not return the questionnaire, filed for worker's compensation when her medical records were subpoenaed. We cannot rule out the possibility that the group was successful in providing most members with viable alternatives to filing stress claims. However, it should be noted that patients who were intent on filing stress claims were excluded from the group. One

TABLE 2
Questionnaire Results

Attitude Toward Work	Same Job	Still Working—New Job	Not Working; Unemployed, Retired	Absent/ Workers' Compensation	Total
Improved	24	6			30
Unchanged	4		3		7
Worse				1	1
No Answer	1		1		2
Total	29	6	4	1	

individual considered filing a stress claim sometime after he participated in the group but did not file. He reported that his work situation worsened, but that the tools he had learned in group helped him find other ways to cope with the problem. Another group member talked about wanting to file a stress claim but decided against this action so that he could continue to participate in the group.

Respondents found the group helped them in four main areas. One primary benefit was the support the group provided. Fifteen respondents felt less isolated and better understood because of the supportive environment provided by the group. A few respondents realized others had problems worse that theirs. The group support helped several respondents feel more confident about themselves.

The second benefit involved respondents' accepting certain situations over which they had no control. Twelve respondents reported they had learned to detach from difficult situations and to take criticism less personally. This allowed them to shift their attention to elements within their control, such as their own attitudes and looking for alternative solutions to their work problem.

Eleven respondents said that the group helped them set limits and become more assertive when dealing with overwhelming work situations. These solutions ranged from standing up effectively to an abusive person at work to learning, in one participant's words, that "I can't do everything myself so I learned to draw the line."

Thirteen group participants reported that they had found specific techniques they learned for problem solving and stress management to be particularly helpful. These techniques included improved communication skills, balancing personal life and work, and stress-management techniques such as relaxation training, improved diet, and exercise.

Discussion

Workplace stress appears to be a growing problem in our complex society. The problem is clearly an expensive one as measured both in dollars and in human suffering. An HMO outpatient psychiatric clinic found increasing numbers of patients presenting with complaints of work stress. Group therapy appeared to be both a useful treatment strategy and a cost-effective alternative to meet this need.

The treatment strategy was designed to help individuals who were experiencing work stress to remain in the work force. Access to an HMO population provided the opportunity to develop a group program. Treatment was cognitive-behavioral, with a focus on developing coping strategies. The agreement to seek solutions other than legal remedies was a requirement for group membership. The group itself provided a significant support system to patients who frequently felt frustrated and alone. The open-ended nature of the group allowed members who had been in the group for longer period of time to act as role models for new members.

The data provided from a 2-year follow-up study seem to indicate that the group was successful. Nearly two thirds of the group participants responded, and 75% of those who responded felt better 2 years later. Seventy-five percent of them were still working at the same job. To the best of our knowledge, only three of the original 62 participants (5%) had filed for worker's compensation. (Because psychiatric records are generally subpoenaed when claims are litigated, this provided a second measure to determine who had filed claims. Psychiatric patients lose their right to patient privilege when they initiate a lawsuit in which they allege psychiatric injury.)

This preliminary study suggests that cognitive-behavioral group therapy can provide a proactive, cost-effective, humanitarian alternative to worker's compensation stress claims. However, the sample studied here is small and limited to one geographic area. The outcome measures were determined by self-report only. However, the findings suggest that treatment for workplace stress can be useful. Further study into this important area seems indicated.

Conclusion

Workplace stress is an expensive and growing problem. Although numerous disgruntled workers have sought legal solutions to their difficulties through worker's compensation, psychotherapeutic treatment may provide a viable and cost-effective alternative. A 2-year follow-up study of psychiatric outpatients presenting with complaints of workplace stress indicates that cognitive-behavioral psychotherapy may, in some cases, be helpful in averting workers' compensation mental stress claims.

References

1. Blodgett N. Legal relief from tension: work-induced stress spurs worker's comp claims. *Am Bar Assoc J.* 1986;72:17–18.

2. California Workers' Compensation Institute. *Mental stress claims in California Workers' Compensation—Incidence, costs, and trends.* San Francisco, CA: California Workers' Compensation Institute; 1990.
3. Levi L. Occupational stress: spice of life or kiss of death? *Am Psychol.* 1990;45: 1142–1145.
4. Sauter SL, Murphy LR, Hurrell JJ. Prevention of work-related psychological disorders: a national strategy proposed by the National Institute for Occupational Safety and Health (NIOSH). *Am Psychol.* 1990;45:1146–1158.
5. Warshaw LJ. Occupational stress. In: Larsen RC, Felton JS, eds. *Occupational Medicine: State of the Art Reviews. Volume 3: Psychiatric Injury in the Workplace.* Philadelphia: Hanley & Belfus; 1988:587–594.
6. Felton JS. Role of the occupational health physician in mental health services. In: Larsen RC, Felton JS, eds. *Occupational Medicine: State of the Art Reviews. Volume 3: Psychiatric Injury in the Workplace* Philadelphia: Hanley & Belfus; 1988:707–717.
7. Brodsky CM. *The Harrassed Worker.* Lexington, MA: Lexington Books: 1976.
8. Mor-Barak ME. Social support and coping with stress: implications for the workplace. In: Larsen RC, Felton JS, eds. *Occupational Medicine: State of the Art Reviews. Volume 3: Psychiatric Injury in the Workplace.* Philadelphia: Hanley & Belfus; 1988:663–676.
9. McLean, AA. Stress reactions in the job setting: case examples. In: Larsen RC, Felton JS, eds. *Occupational Medicine: State of the Art Reviews. Volume 3: Psychiatric Injury in the Workplace.* Philadelphia: Hanley & Belfus; 1980: 639–651.
10. Handron, K, Thomas B. EAPs and workers compensation: handling stress-claim cases. *The Almacan.* 1988; November: 34–37.
11. Corey, DM, Wolf, GD. An integrated approach to reducing stress injuries. *Stress and Well-Being at Work.* Washington: American Psychological Association; 1993.
12. Kirschman E, Scrivner E, Ellison K, Marcy C. Work and well being: lessons from law enforcement. *Stress and Well-Being at Work.* Washington: American Psychological Association; 1993.
13. Martin EV. Designing stress training. *Stress and Well-Being at Work.* Washington: American Psychological Association; 1993.
14. American Psychiatric Association. *Diagnostic and Statistical Manual of Psychiatric Disorders,* 4th ed. Washington, DC: American Psychiatric Association; 1994.